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Perception of professional ethics among senior baccalaureate nursing students

Kelly, Brighid O'Donnell, Ph.D.

The Ohio State University, 1987

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PERCEPTION OF PROFESSIONAL ETHICS AMONG
SENIOR BACCALAUREATE NURSING STUDENTS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the
Graduate School of the Ohio State University

By

Brighid Kelly, R.N., C., M.S.

* * * * *

The Ohio State University

1987

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DEDICATION

To my husband, Jim, and my children, Jim, Jr. and Mary Ellen, whose support and confidence have always strengthened me in times of crisis. To my parents, James and Mary Ellen O'Donnell, whose example has always inspired me.
ACKNOWLEDGEMENTS

I express sincere thanks to Dr. Elsie J. Alberty for her wise counsel throughout my studies at The Ohio State University and in particular for her caring support during this research. I also thank the other members of my committee, Dr. Donald Sanders, whose suggestions contributed to the design of the study, Dr. Gail McCutcheon, who contributed significantly to the interpretation and discussion sections, and to Dr. Mary Ann Ruffing-Rahall whose careful editing added much to the quality of the work. Gratitude is also expressed to Dr. Donna Woodside and Ms. Carrol Quinn, M.S.N., for their comments and recommendations. To my students, both past and present, I have learned and continue to learn from you. And to Dr. Lou Ann Emerson thanks is due for her help in refining the final manuscript.
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ABSTRACT

PERCEPTION OF PROFESSIONAL ETHICS
AMONG SENIOR BACCALAUREATE NURSING STUDENTS

By

Brighid O'Donnell Kelly, Ph.D.
The Ohio State University, 1987
Professor Elsie J. Alberty, Advisor

The problem was explicated as an apparent discrepancy between the values inculcated through professional socialization of nursing students and the apparent compromising of professional values, which takes place in the "real world" of nursing care. The purpose of the study was to investigate, describe and explain what senior baccalaureate nursing students internalize as the professional values, and further to describe what they perceived as a commitment to professional ethics in nursing practice. Seven research questions were posed.
The method was qualitative, specifically it was a blend of inductive as described by Glaser and Strauss (1967) and deductive as described by Miles and Huberman (1983). The sample consisted of 23 senior baccalaureate nursing students of a total population of 120 who were in their final clinical rotation before graduation. Subjects were volunteers who gave informed consent having being briefed on the purposes of the study, and how their confidentiality would be protected. Data were collected three ways: 1) audiotaped interviews; 2) oral responses to a hypothetical ethical dilemma; and 3) written clinical logs. Content analysis was conducted on all data.

Results of the study revealed that subjects perceived two concepts to be central to their view of nursing ethics. These were: 1) respect and 2) caring. Respect was empirically defined by these subjects in terms of respect and evidence of disrespect. Respect was categorized into two main subcategories: 1) respect for patients and families 2) respect for self, colleagues and the profession. Caring was defined by the subjects as "all the little things": showing love and concern; "taking time": getting involved; being cheerful and friendly; being empathic and a good listener; and, being open and honest. Caring was found to be painful and risky.
Conclusions

The following conclusions were drawn based on analysis of data:

Respect and caring were perceived as nursing's essential ethics.

Subjects perceived that ethical nursing was evidenced in ordinary everyday nurse-patient interactions and colleagueal relationships.

"Good" nursing was described as respect and caring for patients and families, self, colleagues and the profession.

"Bad" nursing was described lack of respect and caring for patients and families, self, colleagues and the profession.

Subjects evidenced integration of theoretical ethics in their perceptions of nursing practice.

The "school" was identified as the most influential force in forming subjects' views of themselves as ethical practitioners.

Subjects' responses to the hypothetical ethical dilemma evidenced moral reasoning and they did not perceive an ethical dilemma.

Subjects were not naive about the "real world" of nursing practice.
CHAPTER I
INTRODUCTION

Introduction

Whether one agrees that nursing meets the criteria of a profession, one nevertheless can concur that nursing espouses a professional ideology, i.e., a set of values, traditions, skills and myths which are transmitted to all new members of the group. This process, professional socialization, has been the subject of many studies. For the most part these studies have concentrated on the way in which young professionals assimilate the knowledge and skills of a particular profession with little attention given to the acquisition of the values of that profession. This is possibly because professional values are often not well conceptualized and must, in fact, be inferred from that group's code of ethics - a document which is often idealistic and difficult to translate into everyday practice. Equally idealistic is the notion that all members of a professional group share a common set of professional values or that the values, publicly subscribed to, are adhered to, in everyday practice, by all its membership.
In nursing as in other professions there are values to which the profession subscribes as a whole. These values, such as belief in the inherent dignity and worth of all human beings and their capacity for self-determination, are outlined in the Code for Nurses (American Nurses Association, 1976). This Code is a statement of the fundamental tenets of the American nursing profession. So it should come as no surprise then that nursing educators believe that new members of the profession ought to be committed to these basic values. The question, however, is to what extent are new nursing graduates committed to professional ethics as a foundation of their practice? The purpose of this study, therefore, is to investigate, describe and interpret what senior baccalaureate nursing students internalize as the professional values and further to describe the degree to which they perceive a commitment to professional ethics in nursing practice.

The Problem

The conflict between professional and bureaucratic values has been the subject of many studies. Kramer (1968) studied the values and aspirations of new graduates and did a follow-up study of these subjects two years later. Her findings, now well known by the term "reality shock", was the first in nursing to draw attention to this phenomenon. She found a gradual decline in professional values. She also found that high commitment to
professional values was associated with greater role deprivation, hence the "dropping out" syndrome. Kramer's definition of professional values was a global one and not specifically addressed to professional ethics of nursing, as defined by the American Nurses' Association. She was more concerned with those professional values conflicting with the bureaucratic system. However, autonomy and the ability to provide patient-centered nursing care were part of her operational definition. Kramer was more concerned with those professional values which were in conflict with the bureaucratic system. As a consequence of this study many other studies were conducted in the area of professional disillusionment.

Professional disillusionment, defined as an inconsistency between a person's initial idea about reality and his or her consequent experience with it is often experienced by students long before they graduate (Simpson, 1978). One wonders how this mismatch between the ideals of the profession and the realities of practice impact on the student's own commitment to the values of the profession. Other professions also are concerned with this phenomenon. Pilsecker (1978), in discussing the education of social workers and values education, believes that educators set too high a standard for students while at the same time ignoring the conflicts that exist in practice. He advises educators to bring reality into the classroom and discuss ethical problems and their solutions. Noble and King (1981) also speak of this issue
in relation to social worker education as the idea of passing the torch without burning the runner.

For some time now nursing education has been characterized as having a "head in the sand attitude" with regard to the realities of practice. This is explained in a context which places the nurse educator between two normative systems, specifically the service-oriented bureaucratic hospital and the professional orientation of the academic setting. As Batey (1969:6) states:

Many nursing faculty members continue to operate according to norms of behavior familiar from another position in another type of organization - that of a nurse in a hospital. They expect remunerative and promotion rewards more for conscientious fulfillment of assigned responsibilities of teaching and administrative duties than for the discovery and transmission of knowledge.

Werner (1973) also believes that a credibility gap exists between what nursing educators profess and what they practice saying this gap often leads students to brand faculty as hypocrites. The conflict between bureaucratic values and professional ones is also discussed by Benne and Bennis (1959:380) who state:

On one hand we find schools of nursing and professional nursing associations reinforcing the nurse's self-image as an autonomous, professional person, showing substantial equality in appropriate judgments about treatment processes. On the other hand, we find doctors, perhaps reinforce by the neglect of the study of nurses--if not contrary indoctrination--within their professional education, ignoring or controverting this self-image of a professional person and a colleague which many nurses hold.

While this incongruity must impact negatively on the self-concept of young professional nurses another source
of stress awaits them which potentially is more damaging since it involves their relationship to themselves and their profession. That is their actual implementation of ethical decision-making when faced with numerous and very difficult choices in clinical practice.

Rarely in the past have nurses been confronted with such complex issues and been required to make such difficult decisions. Although it would appear to lay persons that nurses do not have the responsibility for human life that physicians have, each decision reached by physicians, whether ethical or not, in most cases is implemented by nurses. This fact often puts the nurse in the position of having to decide whether or not he/she will participate in a procedure that perhaps is not in the patient's best interest. Nurses are constantly faced with situations in which they are placed in the middle between the patient and the physician. Believing a particular treatment not in the best interest of a particular patient, she may hesitate to voice this opinion lest she be sued for interfering with the relationship between a physician and his patient.

Curtin (1978) in discussing ethical dilemmas and nursing practice says that almost any approach to ethical theory presupposes an agent who is free of undue coercion in decision-making. Yet, ample evidence indicates that where nursing is concerned this is not the case. Curtin (1978) goes on to say that the conflict faced by nurses can be grouped into two broad categories: (1) those which
arise as to institutional policies and physician orders regarding medical care, and (2) those which arise from the usurpation of the legitimate authority of the nurse vis-a-vis nursing decisions regarding nursing care. One has to wonder how conscious and prepared graduating seniors are for the conflicts they face in practice. And, in addition, one wonders in what ways they have assimilated the professional code of nursing into their professional self-concept.

Winslow (1984) in discussing the need for nurses to assume the advocacy role, warns nurses of the hazards involved in the implementation of this role. First, he says, the meaning of advocacy needs clarification. It should not be construed in the paternalistic sense of acting for the client, but, in fact, the nurse needs to serve as a liaison between the client and the health care system. Winslow goes on to say that in general neither the nurse practice acts nor public opinion is clear on what nursing advocacy involves. Finally, he says, because nurses who assume the advocacy role put themselves at risk, they must be prepared for the internal conflict that comes from divided loyalties and interests. Nurses have many conflicting loyalties—they have loyalty to patient and family, the employing hospital, the physician and colleagues, yet the Code for Nurses clearly states that the nurse's first obligation is to the patient.

Although it may seem that nurses' greatest ethical dilemmas must involve ultimate life and death issues, such
as whether or not to participate in an abortion or to "pull the plug" on a respirator at the patient's request, the everyday practice of nurses involves decision-making which while appearing fairly clear cut, requires enormous risk for the ordinary staff nurse; a terminal patient who wants to go home to die, a young teenager who is sexually active and requires information on contraceptives but whose parents disapprove; a cancer patient whose family refuse to tell him the truth; a nursing colleague with a drug or alcohol problem; a patient with an incompetent physician; what to do about painful treatments which are of no use in the case of a terminal patient; how to function in a health care system geared to the paying patient, etc. These are only a few of the problems which await new graduates. As technology increases one can only imagine the increased complexities: Who should be the recipient of transplanted organs? How should we decide? Will this continue to be a case of luck in that it is who you are or who you know? How about artificial organs? Will these be reserved only for those few who can afford to pay? What is the role of nursing in some of these decisions? And finally, how are young professionals being prepared for this future where ethical dimensions of decision-making are only likely to be more complex and numerous? Many believe nursing is not doing a good job.

Aroskar (1977), in a poll taken by the Hastings Center found only 6 of 88 nursing schools required any course work in ethics. Pfeiffer (1980) reports that nursing
faculty complained that an experimental course in ethics was not clinically oriented and an evaluation of its reception at the nursing school revealed that nursing faculty did not wish to discuss ethical issues in clinical conferences. The course was discontinued because of lack of support. It would appear that ethics is not a valued subject in many nursing schools.

Although ethics is integrated content in all nursing courses, the absence of a formal course in ethics bothers many educators. Of greater concern, however, is the lack of discussion of ethical situations. Davis (1980) conceives of four areas of concern: (a) clinical ethical issues; (b) human subjects in research; (c) allocation of scarce medical resources such as machines and personnel; and (d) health policy both at local and national levels. Krawczyk and Kudma (1978) believe a seminar in which students discuss specific ethical dilemmas can contribute more to their moral development than a formal course dealing with theoretical ethics. The problem appears to center on (or around) faculty disagreeing on the way to incorporate ethics into the curriculum. In the meantime students are not receiving formal help in the educational programs to facilitate internalization of professional values.

Teaching professional values is integral to nursing education yet rarely is the acquisition of these values subjected to formal evaluation. The acquisition of knowledge is evaluated through the use of paper and pencil
testing, and the acquisition of skill is evaluated through performance in clinical settings. Conformity to professional role expectations is part of normative assessment on the part of clinical faculty, yet one has to wonder how valid this type of evaluation is since students might demonstrate expected behaviors without actually subscribing to the values represented by the actions. Conversely students' own professional values might not be exemplified in their practice.

As research studies reveal the values students bring to their education direct the development of their orientation (Goldsen, 1960). It would appear that students would resist that which they perceived to be incongruent with their personal values or with their image of their expected role. Since professional socialization is multidimensional, it is expected that students not only acquire professional values and ethics, but that in addition, their personal values undergo change as a result of their acquisition of professional values. Students undergo self-concept changes in addition to role changes. It is believed that students are aware of these changes and can in fact describe them. The purpose of this study is to investigate, describe and interpret what senior baccalaureate nursing students experience as the professional values of nursing as defined by the ANA Code for Nurses. The research questions posed for this study follow:
1. How do senior baccalaureate nursing students construe the term professional values?

2. How do senior baccalaureate nursing students describe their perception of a commitment to professional ethics in nursing practice?

3. What do senior baccalaureate nursing students describe as the influences which have resulted in their present views in regard to professional ethics?

4. How do senior baccalaureate nursing students evaluate their future as ethical practitioners?

5. How do senior baccalaureate nursing students judge the ethical performances of nurses in general?

6. How do senior baccalaureate nursing students perceive that they are implementing an ethical code?

7. How do senior baccalaureate nursing students respond to a hypothetical ethical dilemma?

Significance of the Study

The problem is delineated as a discrepancy between nursing as expounded by nursing educators and the professional code and the practice of nursing as actually experienced by the general staff nurse. Becoming and being a nurse therefore may be an exercise in cognitive dissonance. A recent article suggests that "professional nurses are conceived in moral contradiction and born in moral compromise" (Yarling and McElmurry, 1986:63). These authors conclude that hospital nurses are not free to be moral. Why, one may ask, are nurses not as free as anyone else to act on their consciences? Buckenham and McGrath (1983) assert that "student nurses are groomed for subordination". They conclude from their research that from the moment a nursing students enters the field of
nursing they are presented with images of themselves as subordinate members of the health team. These authors also contend that nursing students are socialized to believe that their acceptance and continued membership in that arena depend on their recognition of that subordinate role.

The link between ethical conflicts and burnout has been described by Gourney (1985) who puts it in the following terms:

"There are a lot of reasons for nursing burnout...but ethical anguish has become a special weight of the past decade...There may be a very strong, direct conflict between what the nurse thinks should be going on and what she's actually doing...She's got, basically, moral schizophrenia."

Research studies have found that nurses experiencing burnout are more likely to perceive they have not been "living up" to their values (Duxbury et al., 1984; Stone et al., 1984). Compromising one's integrity is a major source of stress. Cameron (1986) examines the relationship between ethical anguish and burnout in nursing. She concludes the following:

(1) When coping with moral and ethical problems, nurses may decrease stress and associated burnout by using a well-reasoned, well-informed theoretical framework that helps them maintain their integrity. (2) The more nurses compromise their integrity, the more burned-out they may become. (3) The more burned-out nurses become, the less they may be able to maintain their integrity.

That there is a need for research studies in ethical inquiry is well supported by nurse scientists (Ellis, 1983; Gortner, 1985). Gortner (1985) says that most
ethical inquiry in nursing remains philosophical rather than empirical. Rosemary Ellis says that there is a great need for ethics research which examines "ethics as conceived and lived by nurses". Therefore, the significance of this study is not only in its potential for shedding light on a heretofore unexamined area of professional socialization, which will have implications for the nursing profession in general and nursing educators in particular. In addition this study will add to theory building in nursing by clarifying and describing familiar nursing concepts through empirical data.

**Conceptual Framework**

The purpose of a conceptual framework is to not only provide the theoretical foundation for the study but to outline the major concepts showing the relationships among them and their relationship to the questions under study. Thus, conceptual frameworks are theoretical maps attesting to the investigators' background in the theory which supports the initial study. In this study the major concepts are to be found in the area of professional education and in the sociological viewpoint that all human beings possess an "inner perspective" which they use to interpret and respond to situations every day. The concepts, therefore, to be explored here are professionalism, professional socialization, professional values and symbolic interactionism.
Professionalism

The term professional is one of the most misused and loosely defined words in our language. In everyday conversation one hears it as a noun, "Jim is a professional"; an adjective, "Jim is a professional person"; an adverb, "He acted very professionally". There can be no doubt that it is an emotive term and is a symbol of status. In the classic exploration of the construct Vollmer and Mills (1966) defined professionalism as "an ideology and associated activities that can be found in many diverse occupational groups whose members aspire to professional status". They infer many occupational groups practice activities which would be considered professional, although the occupation itself would not be considered a profession. Strauss (1963) identified four values which encompass the professional ideology: expertise, autonomy, responsibility and commitment. If one judged nursing merely on its acceptance and support of these values, there could be no doubt as to its professional status. However, professional status is not merely determined by subscribing to certain values. One may value and seek power but that does not guarantee that one will possess it.

Greenwood (1957) identified five attributes of a profession:

1. practice based on a systematic body of theory;
2. authority recognized by the clientele of the professional group;
3. broader community sanction and approval of this authority;
4. code of ethics regulating the relations of professional persons with their clients and with colleagues; and
5. professional culture sustained by formal professional associations.

Briefly commenting on these five attributes it would appear that nursing possesses at least three of these. These are: a systematic body of theory, professional authority and a code of ethics. The two that are seemingly in debate are community sanction and a professional culture. The image of nurses as handmaidens to physicians or worse, as sex objects, has been discussed at great length by Kalisch and Kalisch (1985). Tourtillot (1982) believes that nursing does not possess a professional culture because of the values conflicts which exist among nurses. She says the large majority of nurses are detached and uninterested in nursing as a profession and that what is needed in nursing is a commitment toward professionalism. The concept of commitment has frequently been discussed as an important attribute of professionalism and because of its great importance in this study an exploration of this concept is considered essential.

Commitment

Talcott Parsons (1968) defines commitment as "generalized capacity and credible promises to effect the implementation of values". He goes on to the concept of "bindingness". Bindingness implies a presumptive "duty"
to act in the expected manner, including refraining from doing "wrong things". Thus, we see that a commitment is not to be taken lightly but in fact constitutes a solemn agreement between an individual and his/her conscience. Segalman (1970) says that a commitment must necessarily be a quality of enlightened, informed and skill-equipped altruism rather than unadulterated zeal if it is be functional. Being committed to the values of one's chosen profession is considered in that area to be an integral aspect of identification with that occupational role.

Curtin (1982) discusses the nurse's commitment as promises made to society to uphold established standards of practice. She says that "although knowledge and skill are integral to the practice of a profession, the foundation of a profession consists of the performative declarations professed by its practitioners to these promises". Quinn and Smith (1987) also discuss the concept of commitment as likened to making a promise or a contract.

Becker and Carper (1956) believe in four elements of occupational identification: (a) occupational title and associated ideology; (b) commitment to task; (c) commitment to a particular organization or institutional position; and (d) significance of one's position in the larger society. Bess (1978) believes that commitment to the ideology of an occupation is the final state in professional socialization.
Professional Socialization

Professional socialization is best defined by Merton (1961) as the "processes by which people selectively acquire the values and attitudes, the interests, skills and knowledge... in short, the culture current in the groups of which they are or seek to become a member". A literature search reveals that sociologists have conducted the most in-depth studies of professional socialization in nursing so far. These studies (Olesen and Whittaker, 1968; Simpson, 1978) provide a rich description of the ways in which nursing students react to professional socialization.

In the literature of professional socialization the classic study was conducted by Olesen and Whittaker (1968). Some of the most interesting findings pertained to a phenomenon which the authors called "studentmanship" describing underground student behavior playing a very important role in shaping "interactional styles, operational values and staunchly held attitudes" among students. As described, studentmanship was a form of control which students managed to exercise over their world. It was accomplished by deciding what to study and what not to study for an exam, how to bolster a classmate in the eyes of the instructor, how to look appropriately attentive in class and how to look "nursely" on the ward. An example of studentmanship is what Olesen and Whittaker call "fronting". This is described as the ability of the student to control and shape the instructor's image of
them as students. They state that 63 percent of students believed "that many students whose clinical performance is mediocre manage very good grades because they are skilled in putting on a good front before instructors" (Olesen and Whittaker, 1968) and thus are evaluated more positively. For obvious reasons "fronting" is behavior for which a research investigator would want to be aware.

Other findings had to do with two modes of interaction in the process of becoming professional — legitimation and adjudication. Legitimation is defined as the process of others sanctioning the student's claim to the professional role while adjudication is the ongoing "refereeing and negotiating of the minute face-to-face transactions between students and faculty on the technical, refined aspects of role performance as nurses" (Olesen and Whittaker, 1968). Olesen and Whittaker believed the adjudication process to be the heart of becoming professional for these nursing students in the study.

Finally, professional socialization is well described in the following excerpt from Olesen and Whittaker:

It was not in the high council of the curriculum planners, nor in the skill of the most sophisticated and understanding instructor, nor in the late night cramming for exams that professional socialization occurred. Embedded in the frequently banal, sometimes dreary, often understanding world of everyday living, professional socialization was the common place. In the mundane, not in the abstract or exalted, occurred the minute starts and stops, the bits of progress and backsliding, the moments of reluctant acquisition of a new self and the tenacious relinquishing of the old; the flush of pride and elation when telling a fellow student about a good evaluation or listening silently and
painfully when being told of someone's else's good marks; the feeling of relief that one had not been the object of group laughter in conference; the sense of anxiety when learning from a classmate that yet another student had married or become engaged; the right look at the right time when discussing the patient with the instructor.

These matters constitute the silent dialogue wherein are fused person, situation, and institution. Therein lies the heart of professional socialization. (Olesen and Whittaker, 1978:296).

Professional Values

The values of professions are grounded in ethics. Ethics is "a branch of philosophy relating to human conduct with respect to the rightness or wrongness of certain actions and to the goodness and badness of the motives and ends of such actions" (The Random House College Dictionary, 1972). In the 19th century the study of values became recognized as one of the great philosophical topics of all time (Encyclopedia Brittanica, 1977). The development of a theory of value was considered to be such a great achievement that a special name - axiology - was given to that area of science. Yet "value theory" is still discussed most places under ethics in the broader context of moral philosophy.

According to Frankena (1973) one must distinguish three types of thinking that relate to morality. (1) the descriptive empirical inquiry conducted by anthropologists, historians, sociologists and psychologists in which the goal is to describe or explain
ethical conduct; (2) meta-ethical thinking in which no attempt is made to answer particular questions about what is "good", "right", or obligatory, but rather concerns itself with asking questions about the nature of morality and to seek answers to such questions as, "how can value and ethical judgements be justified?" and finally, (3) normative thinking concerning itself with what is right or good in a particular circumstance and forming judgements as a conclusion to that process. Because of the latter, normative ethics is the kind in which health care workers engage in most frequently, this area will be the ethical theory most directly explored in this study.

**Normative Ethics**

Normative ethics is divided into two major categories: (1) deontological theories and (2) teleological theories (Frankena, 1973). The first emphasizes duty to others as paramount while the second places emphasis on the consequences of actions as being more important than the actions themselves.

Deontological views are all traced to Kant (1956) who first outlined the principles of this theory. Kant believed that one's ethical decisions should be made with the thought that one's actions become universal laws. In other words, "what if everyone did what I'm doing?" The idea here is that one should always act toward others as one would wish others to act towards oneself. In this
context duty to others is uppermost and the rule by which one lives.

In teleological theories no action in itself is either good or bad. The only thing that makes a certain action good or bad is the consequences that result from it. Frankena (1973:15) says, "A teleological theory says that the basic or ultimate criterion or standard of what is morally right, wrong or obligatory, etc, is the nonmoral value that is brought into being." He adds that teleologists differ on the question of whose good one ought to promote. Ethical Egoism and Utilitarianism are two differing schools of thought within teleological theories. Ethical egoism takes the position that one should always do that which promotes his or her own good, while utilitarianism holds that the ultimate end is the greatest general good. Utilitarians, therefore, believe that ends are more important than means in promoting good over evil. These views of ends and means therefore become the most crucial difference between deontological theories and teleological theories. At the risk of over simplification, deontologists have a different view of what "good" is than do teleologists. Kant, as deontologist, affirms that persons are always ends in themselves and that a person is never treated as a means. Mill, (1949) as a utilitarian, affirming the principle of the greatest good for the greatest number, sees no problem in treating persons as means to and end.
Three distinct major moral principles, respect, beneficence and justice, have emerged from the deontological perspective and have been discussed by Davis and Aroskar (1983) with relevance to nursing. According to Davis and Aroskar respect encompasses self determination and autonomy and acknowledges the interconnectedness and interdependence of people. This principle gives direction to the nurse to see people as persons with unique needs and that all decision making should take into consideration the person's values and own goals.

According to Davis and Aroskar, (1983) beneficence is a principle which not only speaks to the promotion of good for all persons, but also the non-infliction of harm. This principle also provides direction to nurses in the area of balancing benefits with risks in any given situation.

The principle of justice provides guidance to nurses when considering that all persons be treated fairly. This involves moral consideration of the comparative treatment of persons, giving due consideration to the effects of different treatments based solely on ability to pay.(Davis and Arokar, 1983)

No discussion of theoretical ethics would be complete without some discussion of moral development and what current thought is in that area. Kohlberg (1981) has been the considered expert in this area for many years. Kohlberg identified six distinct stages through which an
individual progresses in moral development. The six stages are further categorized into three levels. These are the preconventional, conventional and post-conventional.

The first level, preconventional, consists of stage one and two in which the child sees that moral values reside outside himself/herself. At the second level, conventional, consisting of stages three and four, the young person sees that moral values reside in performing "good" or "right" roles and meeting the expectations of others. At the post-conventional level the person conforms to a shared standard of moral values, rights and duties. According to Kohlberg at the post-conventional level the person seeks to find moral values which are distinct from his or her identification with group values. Kohlberg believes that only one in five Americans ever reach this stage of moral development. However, Kohlberg's theory has recently come under criticism from one of his own students.

Carol Gilligan (1977) found that all of Kohlberg's original research was based on the male model and that when the same research tools and theoretical concepts were used with women subjects they did not demonstrate moral development beyond the third stage or the conventional level. This finding led Gilligan to do an in-depth re-examination of Kohlberg's theory and how women's moral development differed from men's. Gilligan's empirical study (1982), traced through the voices of women, revealed
that women construe reality differently from men. These differences center around experiences of attachment and separation. A woman's sense of integrity seems to be intertwined with an ethic of care and a tie between relationship and responsibility. Gilligan concludes that because women are judged by the male standard of morality, they are judged as inferior rather than different.

Gilligan's resulting model (1977) has also three levels but has two transitional states. In level one the child sees that morality is imposed and that being moral is being submissive. In the transitional phase between level one and level two the young person finds that responsibility for and to others is more important than submissiveness. In level two the person finds that being moral is not hurting others. In the transition phase between two and three responsibility shifts from not hurting others to also include not hurting self. At level three not hurting becomes the governing principle. The principle of care becomes a universal obligation.

According to Gilligan (1979) the majority of women prefer to discuss moral problems in terms of concrete situations. They approach moral problems as human problems which need to be solved. Gilligan (1979:440) describes the approach:

Women not only define themselves in a context of human relationships but also judge themselves in terms of their ability to care. Women's place in man's life cycle has been that of nurturer, caretaker, and helpmate, the weaver of this network of relationships on which she in turn relies.
Thus, Gilligan's model adds an important dimension to the study of ethics in nursing since approximately 97 percent of nurses are women and nursing has been historically viewed as a caring profession. Ethical guidance is provided to nurses in the professional code of ethics - the Code for Nurses. A brief history of this document is now provided.

The ANA Code for Nurses. The birth of modern nursing in the United States took place in the last quarter of the 19th century (Kalisch and Kalisch, 1986). Not until 1926 did the first tentative code of ethics appear in the American Journal of Nursing. That "Suggested Code of Ethics" was reviewed by the Delegates of the American Nurses Association Convention for further work, and approved at the 1928 biennial (Flanagan, 1980). Its first revision occurred in 1940, the second in 1950, the third in 1968, and the most recent in 1976.

The first suggested code of ethics (1926) spoke to the nurse's relationship to the patient, the physician, allied professionals, peers and the nursing profession. It specifically outlined the nurse's responsibilities to these groups. In subsequent revisions references to the nurse's responsibility to the physician were modified excluding any mention at all of the physician. Instead, references to the nurse's responsibility to client and the public successively became stronger and some additions to the code were the nurse's role in research and personal conduct with regard to representation of the profession to
The Code for Nurses as it now reads is presented in Table 1.

The values represented by the Code have been summarized by Murphy (1986) as follows:

- having respect for persons
- having self-determination
- acting on the best interests of or doing what is good for patients
- avoiding and preventing harm to patients
- telling the truth
- maintaining confidences and privacy
- maintaining trust and keeping promises
- treating people fairly

These, then, are the values of the nursing profession to be internalized by new members to the profession.

Olesen and Whittaker (1968) relate internalization with professional socialization in the following way:

Socialization does not only involve the recognition of an assumed identity by the outside world. It also involves the individual's recognition of the identity within himself and the non-deliberate projection of himself in its terms. This process is usually referred to as internalization and it depicts the success of past socialization. The internal image of oneself—the self esteem—is accomplished through internalization of not only one's own judgements about oneself but also the perceived judgements of others of one. Thus, nursing students construct their image of the kind of professional nurse they will be. The body of knowledge surrounding this concept is called symbolic interactionism.

Symbolic Interactionism. Symbolic interactionism is a theoretical approach to human behavior the origins of which can be found in the work of George Herbert Mead
Table 1

CODE FOR NURSES

1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4. The nurse assumes responsibility and accountability for individual nursing judgments and actions.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgement and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employent conducive to high quality nursing care.

10. The nurse participates in the profession's efforts to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

(A.N.A., 1976)
(1934). However, most contemporary sociological views on symbolic interactionism have come from the teachings and writings of Herbert Blumer. Blumer's (1969) view is that humans act toward "objects" on the basis of the meanings that such objects have for them. According to Blumer humans interpret rather than merely respond to others. Symbolic interactionists place great emphasis on the process of social interaction. All groups possess a common language through which meaning of action and interaction is shared. Therefore, if one is to come to understand the meaning of a particular group's language and what it symbolizes, one must seek to view the world as the group does. This often requires that the investigator become a member of the group in order to come to know their experiences, understand their language, know their definitions and symbols of communication. An important and complementary view of human behavior is presented by Goffman (1959). According to Goffman people present themselves to others on the basis of the impression they wish to convey. In other words, "they put on a show". Goffman refers to this research approach as dramaturgical. The use of this research perspective allows the investigator to step outside a very familiar situation and in describing events as seen through the eyes of the participants avoid the fallacy of objectivism. The fallacy of objectivism has been described by Buckenham and McGrath (1983) as overlaying the data with the perspective and biases of the researcher.
The method chosen for this study is grounded theory based on the symbolic interactionism of Blumer and Goffman. The author will provide details in Chapter 3.

Summary and Overview

In this chapter the nature of the problem under study was explored in depth. The problem was described as a discrepancy between the values of nursing as expounded by the profession, and nursing educators in particular, and those evidenced in nursing practice.

Seven research questions were identified which were aimed at uncovering how emerging professional nurses perceive the professional values of nursing, in particular as these are outlined by the ANA Code for Nurses.

The conceptual framework for this study provides a foundation of theory in explicating the major concepts of this study. These are professionalism, commitment, professional socialization, professional values and symbolic interactionism. The importance of these concepts and their relationship to each other is this. Professionalism and professionalization are concepts essential to the understanding of professional values. Professionalism and commitment are connected in that new members of professions are expected to accept and subscribe to the professional values. The professional values are transmitted to new members through the process of professional socialization. Professional socialization provides the student with a language and other symbols of
the profession. Symbolic interactionism is the theoretical perspective best suited for the study of these symbols and meanings.

Chapter 2 presents a review of the literature in reference to relevant issues in professionalism, professional socialization and professional values.

Chapter 3 provides a detailed examination of issues in qualitative methodology with emphasis on grounded theory. It provides details regarding the method used in this study and an in-depth step by step guide to the procedure used in both data collection and data analysis.

Chapter 4 presents the results of the study.

Chapter 5 presents the main conclusions derived from the study in the form of a theory. The implications of this study are discussed and recommendations made for further research in this area.
CHAPTER II
REVIEW OF THE LITERATURE

Introduction

This chapter will focus on the literature relevant to the major concepts of the study. It begins with a review of current thought in the professionalization of nursing and continues with a review of studies in the professional socialization of nursing and of the literature surrounding nursing ethics.

Professionalism in Nursing

According to Hall (1982: 6), power is the critical defining characteristic of a profession. He identifies the following requirements of power in professions:

- Power provides a profession with the capacity to have legislation passed while protecting its area of practice.
- Power provides the capacity to establish agreed upon credentials.
- Power provides the capacity to demand and receive reasonable levels of compensation.

Hall believes that nurses are blocked from having this power by physicians even greater power which he says operates against nursing. Although Hall does not say
that nursing is not a profession, he does provide support for the notion that nursing is a semi-profession quoting Ritzer (1977) who describes nursing as a "female semi-professional". Braito and Prescott (1978) also believe that nurses possess many of the characteristics of blue collar workers. For example, they say, nurses are concerned with issues of salary and working conditions. Does one conclude then that white collar workers are not concerned with these issues? Hall (1982) implies that nursing is engaged in the process of professionalization and he advises nurses to look to their professional organizations for the empowerment of nursing as a profession.

Empowerment through "professionhood" is the thesis of Styles (1982a) who believes that the old model of professionalism is outmoded and not an appropriate one for nursing. Defining "professionhood", Styles identifies its three attributes: (1) a sense of social significance regarding nursing and ourselves, (2) commitment to ultimacy of performance in our work, and (3) the twin attitudes of collegiality and collectivity. Styles (1982b) sees the need for unity among nurses as one of the most important steps in professionalization. She calls for solutions to the problems which she sees as obstacles in that process. Styles calls for nursing to assume a leadership role in setting standards for nursing service in hospitals, to become unified on the professional education requirements for entry into the
profession, to come to a consensus on a nursing definition and less diversity in the licensing system. Finally, she supports excellence in specialty practice through certification of nursing specialists.

While most nursing leaders appear to agree with Styles on the stumbling blocks in the professionalization of nursing, the large majority of nurses are more concerned with the more mundane problems of nursing practice. In a recent poll taken by Nursing Life (1983), to which 2,284 responses were received, 58 percent of nurses agreed that there were too many non-direct patient care activities, most complained of the amount of paperwork. Fifty-four percent saw that staffing as inadequate, 48 percent thought that interdepartmental politics hurt the quality of care, and 39 percent felt they did not receive adequate support from nursing administration. Hence, there appears to be a gap between the highly educated nursing leadership, who are a small minority of nursing, and the vast majority of nursing who are, according to Tourtillot (1982), not all committed to professionalism in nursing. Too many of the large majority view nursing as a job, not a career, and ego involvement is minimal. Cohen (1981), found that the students in her sample expected nursing to be secondary to their main interest in life, their family-to-be. In her study, 90 percent of her sample felt this way.

Students' views of nursing as a profession were presented by Melia (1983), who found that although the
majority of nursing students in her sample believed that nursing was a profession, they also believed that many of the tasks called nursing could not be called professional. In elaborating on this view, Melia says students used two terms in describing nursing. These were: "real nursing" and "basic nursing care". "Real nursing" was a term used to describe technical procedures medically prescribed which are commonly done on surgical wards; while "basic nursing care" was the care which was independent of medical prescription and thus was often described as "anyone can do it". The view that "anyone can do nursing" is probably the most pervasive obstacle to the professionalization of nursing and has been discussed by Johnson (1978:10) who says:

Perhaps the greatest stumbling block to professional elevation is the vast range of work which goes under the nursing rubric. Nursing auxiliaries are not only numerous, they carry out work of an undeniably important kind with little or no training.

Thus, we become aware of the problems which nursing is grappling with on the road to professionalism. Donna Diers (1986), believes that the image of the nurse held by society at large is outdated. Perhaps the image of nursing held by the average nurse is also outdated. This brings us to the process of professional socialization from which nurses receive their image of nursing.
Professional Socialization

One of the most revealing studies of professional socialization in nursing has already been discussed, the Olesen and Whittaker study. The next major study was Simpson's (1978) study. Simpson examined the professional socialization of 517 nursing students over a six year period between 1959-1965. An interesting mismatch was discovered between the values of the collegiate nursing program and the values of the products of that program. While the objectives of the nursing program were patient-centered nursing continually reinforced by the nursing faculty over four years, freshmen were more holistic and idealistic in their orientation to nursing care than they were at graduation. Students emerged from the program espousing a bureaucratic conception of nursing. As new graduates, they were task-oriented and valued technical proficiency over patient interaction.

Simpson attributes this outcome to the fact that most clinical experiences occurred in hospitals and the nursing faculty were often very concerned about technical competence. An example of the incongruity of this position was students' reports of much emphasis on understanding the patient's needs yet faculty did not encourage interpersonal contact with patients until after all assigned procedures were finished. Faculty expected students to "look busy"; sitting with a patient after tasks were completed was taken by the faculty to be further evidence of efficiency. Simpson concluded that
while entering students' values were congruent with the
ideal goals of the faculty, the students' hospital
experiences were incongruent with both.

Cohen (1981) examined the role of the educational
system in the socialization of nursing students and
concluded that throughout her education, the student is
socialized to be subservient and receives two conflicting
messages from nursing faculty. Examples of such messages
are provided by Cohen as follows:

If you are going to be a nurse, you must be
perfect, never fail, and be a fully responsible
individual; however, you are a hand-maiden to the
physician and you must make sure you do as both
the physician and the instructor tell you.

If the nurse is not perfect, the patient may die.

Nurses must assess and make judgments; however,
students must learn by rote and must never
question or resist or they will be called
troublemakers. (Cohen, 1981:140)

Cohen's data support the view that these conflicts
are inherent in the nursing culture. Cohen phrases it
thus: "The requirements for a subservient, dependent
demeanor must be reconciled with the demand for perfection
and the fear of killing a patient". The result, according
to Cohen, is an atmosphere where nursing students feel
constricted and spied upon and where the very students
who would make the best professionals are driven out of
nursing because they are too assertive.

The importance of role models to professional
socialization has been discussed by Simpson (1964) and by
Cohen (1981). From their works, students appear to seek
a model who portrays their own ideal conceptions of the profession. What is not clear, however, is what happens if the student never finds a person with whom to identify. On the other hand, Bucher and Stelling (1976) say that some students find qualities in many professionals which they admire and seek to emulate and other students select one person and attempt to become like that person.

The influence of peers has been described by Becker and Geer (1958) in their study of medical students. They speak of a "student culture" which provides support for students, hence permitting them to withstand the stress of professional education. Also, student culture affects the socializing process in that it often influences the amount of time students spend in study or an exam and the students' view of the faculty. Students helping each other to get through often assume a "we versus they" attitude.

Melia's research (1983) on the views of nursing students regarding their education was one of the first professional socialization studies conducted by a nurse. From indepth open-ended interviews with 40 nursing students, this investigator found that nursing students attempted to "fit in" at all costs. For instance, one student stated that "even before you begin to think about taking care of the patients, you think about getting along with the staff". Melia points out that in some ways the students' whole training can be viewed as a tactical game with little time to learn the ground rules before passing
through to the next round. Another feature of these research findings was the way in which students rationalized any situation which "didn't square" with what they were taught in college. Students used their transiency as a means of coping with values conflicts. An example of this is as follows:

...there is no way you are going to change the routine on night duty; you just have to play along. You are only there for six weeks there's not much point is stirring things up (Melia 1883:26).

One wonders if these students really believe that they can make significant change after they become qualified.

Buckenham and McGrath (1983) found that the most powerful theme emerging from their research to be students' perception of themselves as members of the professional health team. These authors set out to investigate why the registered nurses in their study evidenced such a discrepant role in practice. Having evaluated the schools of nursing of their subjects, they were satisfied that the curriculum supported professional values. They then investigated clinical learning context that might lead to unprofessional behavior in practice. They found that nursing students perceived two teams in the hospital setting who held different views of reality, the patient team and the health team, with the student belonging to the latter. Not only did the health team see things differently from the patient team, but according to these authors, the nursing students perceived that the health team's view was the "real" or true view.
Accordingly, the health team is able to determine whether a patient has "really" slept, is "really" getting better or is "really" in pain. Thus, nursing students perceived that though they were low on the hierarchical system they were still above the patient team.

Another important finding was that students very soon come to know "their place". They learned deference to more senior members of the team. The authors point out that "student nurses" do not question the importance of the medical students' tasks as compared to theirs. One nursing student said "sometimes they'll let you get on with your work", the inference being that at other times the student must stop what he or she is doing for a patient in order to allow medical students to get on with their objective.

Despite the subordinate role assigned the nursing student, membership in the team provides the student with sufficient compensation to counterbalance the more demeaning aspects of this role. These compensations are identified as notions of superiority and a sense of power which are by-products of team membership.

It appears from this study that nursing students learn a great deal about compromise in their educational experience. It is hoped that the present study will result in a fuller understanding of the relationships embedded in the ethical aspects of professional education.
Ethical Inquiry in Nursing

The ethical perspective in nursing has been the focus of a number of writers in recent years. Among these are: Davis and Aroskar (1978); Thompson and Thompson (1981); Curtin and Flaherty (1981); Benjamin and Curtis (1982); Thompson, Melia and Boyd (1983); Muyskins (1983); Bandman and Bandman (1985); Rumbold (1986); Fromer (1986) and Quinn and Smith (1987). A review of these texts will soon alert the reader that ethics is defined in a variety of ways. Davis and Aroskar (1978) define ethics as a branch of philosophy which dealing with questions of human conduct. Curtin and Flaherty (1981:44) say ethics "proposes to identify, organize, examine and justify human acts by applying certain principles to determine the right thing to do in specific situations". Thompson and Thompson (1981:2) say ethics "refers to the principles behind the shoulds and whys of a moral code or statement". Benjamin and Curtis (1982:6) believe ethics "is an attempt to formulate and justify systematic responses to the following question: What, all things considered, ought to be done in a given situation". Thompson, Melia and Boyd (1983:4) say that ethics "refers to the general area of rights and wrongs of human behavior. Bandman and Bandman (1985) also believe that ethics refers to the good and "ought" of human behavior. Rumbold (1986) says ethics is concerned with the memory of such words as "right", "wrong", "good" and "bad". Finally, Quinn and Smith say ethics consists of "values that a person uses as rules or
principles to make decisions". In all of these definitions it can be understood that ethics provides the knowledge and guidance necessary to help individuals and groups make "right" decisions. In all of these texts, the nurse's problem with ethical dilemmas is explored and discussed.

An ethical dilemma is defined by Benjamin and Curtis (1982:23) as a "situation requiring a choice between what seems to be two equally desirable or undesirable alternatives", and there appears to be a consensus about this definition. The exploration, delineation and analysis of common ethical situations mark the focus of most of these authors. Those situations most often discussed are in the following areas: the sanctity of life versus the quality of life; providing information to the patient versus withholding information; the patient's self-determination versus health care paternalism; protecting the patient from incompetence versus protection of an incompetent colleague; patients' right to confidentiality versus others need to know. It appears that working nurses would agree with these categories. Davis (1981) reported the results of a survey conducted in the San Francisco Bay area of California where 205 registered nurses responded to a questionnaire. These nurses were asked to describe incidents in which they faced ethical dilemmas. The most frequently described categories were: (a) prolongation of life with heroic measures, (b) unethical or incompetent conduct of
colleagues, (c) confidentiality, (d) violation of patient autonomy, and (e) withholding treatment. Also, Crisham (1980), in gathering data for the development of an instrument, found the following situations to be the most commonly encountered ethical situations: the newborn with anomalies; forcing a patient to take medication; an adult's request to die; distribution of nursing resources; medication errors, and finally, the right of a terminally ill patient to know the truth. While it is of great importance to know the areas where nurses agree are ethical dilemmas of equal importance is knowing how the typical nurse perceives her ethical role.

In 1974, Nursing '74 conducted a survey in which 11,000 responded to 55 questions dealing with what they considered to be "right" or "wrong" in professional behavior. The results revealed:

- 52 percent through their professional standards were higher than those of other nurses
- 58 percent felt most confident in their nursing abilities
- 67 percent would not report a colleague who had admitted taking amphetamines on duty
- 53 percent would do as the supervisor said when asked by a physician to give excessive doses of a drug to a patient
- 48 percent often felt used as servants by some doctors

(Nursing Ethics Probe, 1974)

More recently 5,000 nurses responded to a poll conducted by NursingLife, revealing the following:
83 percent said they have had to compromise their ethical values for some reason.

25 percent of those who compromised their ethical values were mostly concerned about getting into legal trouble.

57 percent said they were sometimes dishonest with patients.

90 percent admitted to having made a medication error.

36 percent said they had falsified records or known someone who had.

88 percent believe that withholding information from a patient is sometimes acceptable or justifiable.

52 percent had deceived a patient about a medication taken.

33 percent would avoid answering the patient's questions about an incompetent doctor.

80 percent think its all right to give placebos.


A smaller, more localized survey was conducted among the participants of two separate conferences held in Louisville, Kentucky in May 1985. One hundred thirty-four (134) participants responded to the survey. The demographic data revealed that of the 124 who reported educational status, 4 percent held doctorates, 37 percent held master's degrees, 29 percent held baccalaureate degrees, and 25 percent held an associate degree. In relation to area of practice, 41 percent were employed in hospitals, 39 percent in schools of nursing, 8 percent in community agencies, 6 percent miscellaneous and 2 percent in nursing homes.
The participants were asked to check the five most commonly occurring problems arising in their practice and to also identify the three items which had the greatest potential for generating ethical dilemmas today. In answer to the first question the most common ethical practice problem, the results are shown below:

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<td>Documentation</td>
<td>64</td>
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<tr>
<td>Lack of administrative support</td>
<td>51</td>
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<tr>
<td>Code-no-code</td>
<td>49</td>
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<tr>
<td>Compliance to medical treatment</td>
<td>37</td>
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<tr>
<td>Informed consent for medical treatment</td>
<td>35</td>
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<tr>
<td>Resolving value conflict</td>
<td>35</td>
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<td>Confidentiality</td>
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<td>Lack of collegial support</td>
<td>33</td>
</tr>
<tr>
<td>Incompetent colleagues</td>
<td>29</td>
</tr>
<tr>
<td>Incompetent physicians</td>
<td>29</td>
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</tbody>
</table>

In answer to the second question regarding areas of greatest potential for generating ethical dilemma, the results are as follows:

<table>
<thead>
<tr>
<th>Item</th>
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<tr>
<td>Economics and distribution of scarce resources</td>
<td>66</td>
</tr>
<tr>
<td>Access to care for medically indigent</td>
<td>65</td>
</tr>
<tr>
<td>Treatment versus non treatment</td>
<td>43</td>
</tr>
<tr>
<td>Care of elderly patients</td>
<td>28</td>
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<tr>
<td>Competence in nursing</td>
<td>26</td>
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<tr>
<td>Informed consent</td>
<td>20</td>
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<tr>
<td>Nursing autonomy</td>
<td>20</td>
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<tr>
<td>Care of the dying patient</td>
<td>18</td>
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<tr>
<td>Genetic engineering</td>
<td>18</td>
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<tr>
<td>Reproductive issues</td>
<td>18</td>
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<tr>
<td>Abortion</td>
<td>17</td>
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<tr>
<td>Professional role of the nurse</td>
<td>16</td>
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<tr>
<td>Experimental treatment</td>
<td>15</td>
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<tr>
<td>Organ transplant</td>
<td>15</td>
</tr>
<tr>
<td>Paternalism/advocacy</td>
<td>13</td>
</tr>
<tr>
<td>Staffing patterns</td>
<td>11</td>
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<tr>
<td>Respect of persons</td>
<td>9</td>
</tr>
<tr>
<td>Conflict of interest</td>
<td>1</td>
</tr>
</tbody>
</table>

(Ethical Issue, 1987)
These surveys show that some contemporary nurses are concerned about ethical issues. The data from the NursingLife Surveys convey the impression that nurses live with compromise. One cannot help wondering how often compromises are rationalized as "all that can be done under the circumstances". It has been said that ethics cannot be divorced from the social setting from whence they emerge (Davis, 1981). It is possible then that the norms prevalent in the health care setting, which are not geared to consumer power, make ethical decision-making a risky business.

Research Studies in Ethics  Research studies involving ethics or values in nursing are relatively recent. The fact that most of the early investigation was philosophical and not empirical is probably due to the reluctance of many investigators to study a concept which was difficult to study due to lack of constructs and tools. In current nursing research literature, three instruments are being used in ethical inquiry: Defining Issues Test (DIT), Judgments About Nursing Decisions (JAND), and Nursing Dilemmas Test (NDT). The Defining Issues Test (DIT) involves six hypothetical stories about a moral dilemma. For each story, the subject is asked to rate twelve statements according to the importance they would give that statement. Finally, the subject is asked to rank the issues they value in analyzing ethical issues (Ketefian, 1981a).
The Judgments About Nursing Decisions (JAND) (Ketefian, 1981a), is comprised of six stories, each depicting a nurse in an ethical dilemma. It measures two components of moral behavior: (1) knowledge and valuation of moral behavior, and (2) perception of realistic moral behavior. In other words, the instrument in Column A seeks an answer to the question, "What should nurse X do in this situation?" In Column B, it asks the question, "What do you think nurse X will do in this situation?" Ketefian (1987) in discussing this test says the initial intent was to gain insight into what nurse respondents thought they should in an ethical dilemma. It appears the unidentified assumption was that respondents, in choosing the best action for the nurse in the story, were identifying the action they would take.

The Nurses Dilemmas Test (NDT) (Crisham, 1980) presented the subject with six ethical dilemmas which had been developed based on interviews with staff nurses. The subject is asked to do three tasks, (1) decide what the nurse should do, (2) rank the moral and practical consideration in order of importance, and (3) indicate degree of involvement with a similar dilemma. Using this instrument, Crisham (1980) found that level of education was significantly related to level of moral judgments. In Crisham's study, five subject groups were studied (N=225), staff nurses with associate degrees (n=57), staff nurses with masters degrees (n=85), undergraduate nursing students (n=36), and non-nursing students (n=37). In
investigating moral judgments in real life situations, it was found that the masters degree prepared nurses had the highest scores while the most experienced staff nurses had lower scores than junior year beccalaureate nursing students and non-nursing graduate students. The interpretation was that staff nurses gave significantly greater importance to "practical considerations" than to nursing care. Crisham concluded that the importance attributed to practical considerations and the evident lack of principled thinking which appeared correlated with length of clinical nursing experience, affirmed the significance of formal education in enhancing principled thinking.

Ketefian (1981a) studied the relationship between moral reasoning and moral behavior in 79 practicing nurses, 43 of whom had a professional education and 36 of whom had a technical education. Using the DIT and JAND tests, she found a significant difference between the two groups as to knowledge and valuation of ideal moral behavior. The baccalaureate students being more knowledgeable. No significant difference was found between the two groups regarding perception of realistic moral behavior in a nursing dilemma. The author concluded that professional nurses' knowledge and values were not being translated into reality. One must also consider that the lack of difference in perception of realistic moral behavior could simply mean that both professional and technical nurses were simply "telling it like it is".
Ketefian (1981b) utilizing the same sample of nurses subsequently found a positive relationship between critical thinking and moral reasoning, and between level of formal education and moral reasoning. Ketefian concluded that the differences found between the baccalaureate nurses and the diploma nurses may be explained by the rapid professionalization of nursing education.

Felton and Parsons (1987) also found a relationship between education and ethical decision-making. In a study of 227 baccalaureate nursing students and 111 graduate nursing students, in which the authors used the DIT test, results revealed that graduate students reasoned at a higher level than undergraduates. However, the ability to solve ethical dilemmas did not differ significantly in the two groups, both groups scoring high in ethical dilemma resolution. The authors questioned the lack of correlation between the moral reasoning scores and the ethical dilemma resolution scores as perhaps indicative that students did not recognize the situations as dilemmas.

Gaul (1987) sought to examine the effect of an elective nursing ethics course on 17 undergraduate nursing students enrolled in the course in comparison with 20 undergraduate students who were not enrolled in the course. Using the JAND test to measure moral reasoning ability. The author discovered that while the overall scores of the two groups were not significantly different,
the scores of the groups in the ethics course were higher overall. Although the investigator attributed some of this to repetitive in-class experience, she did not explain why students not enrolled in the ethics course scored so highly on the JAND.

Education and practice experience in relation to moral reasoning was the focus of Mayberry's study (1986). In this case, the subjects were 130 hospital staff nurses and 37 head nurses who were employed in a range of large and small hospitals. Using the DIT test, results revealed that education alone was the most powerful and consistent relationship with moral development and principled decision making. She also found that work environment was a strong influence on individual moral judgments, and that increased length of practice experience was associated with less principled reasoning ability.

Because this current study will examine the forces influencing nursing students in forming their ethical standards as beginning professionals, a review of research in this area is particularly significant.

Swider et al. (1985) examined ethical decision-making by senior student nurses. The study involved a classroom exercise in which priorities in decision-making were examined when students were presented with a case depicting an ethical dilemma in nursing. The ethical dilemmas revolved around a nurse who became aware that the hospital was covering up the death of a patient due to overmedication. The subjects were 175 senior
baccalaureate nursing students from 16 midwestern colleges and universities. The students worked in groups of five and their task was to arrive at a course of action to deal with the dilemma. The resultant decisions were categorized into three areas. These were: (1) patient-centered, (2) physician-centered and (3) bureaucratic-centered. The results revealed a mean number of 8 decisions per group and of the total 1,163 decisions made, 9 percent were patient-centered, 19 percent were physician-centered, and 60 percent were bureaucratic-centered. It would appear from these findings that the senior student has already become bureaucratic in problem-solving.

The most consistent common denominator in all of these studies is the importance of education to ethical awareness. However, knowledge does not appear to be translated into practice. It appears that although nurses seem to know what the ethical course of action is, they appear to indicate that the typical nurse would not take this action. This view is supported by the findings of the studies in which JAND was used. These studies revealed that while nurses scored high on valuation of ideal moral behavior, they evidenced by their choices on Column B that the nurse in the story would not always take this action. Is this an indication of how nurses in general perceive each other?
Summary

This chapter reviewed the literature relevant to the study. Issues in professionalism and the professionalization of nursing were reviewed and current thinking by nursing leaders was discussed. Studies with relevance to professional socialization in nursing were reviewed and questions raised regarding that process. The current status of ethical inquiry in nursing was explored and research studies with particular relevance to this study were presented. The next chapter will provide a detailed discussion of the research method used in this study.
CHAPTER III

METHOD

Introduction

The purpose of this study is to describe how senior baccalaureate nursing students experience their ethical role on a daily basis and further describe how they perceive a commitment to ethics in nursing practice. Since the questions addressed in this study are concerned with how nursing students construe the social reality of nursing, the research method is qualitative. More specifically, as will be discussed, the method is partly inductive as devised by Glaser and Strauss (1967) and partly deductive as outlined by Miles and Huberman (1984). The population under study is senior baccalaureate nursing students and the setting is a large suburban university. Data were collected in three segments: (1) audiotaped interviews, (2) response to a hypothetical ethical dilemma, and (3) content analysis of subject's clinical logs.

Qualitative Method

The use of qualitative method in this study is
consistent with the sociological viewpoint which acknowledges intersubjective reality, and that all humans seek meaning in their interaction with others and that in order for the researcher to come to understand the social reality of the subject, she must adopt the subjects' perspective. The Chicago School of Symbolic Interaction calls this feeling one's way inside the experiences of the actor (Blumer, 1969). Symbolic interactionism was considered to be the theoretical perspective most appropriate as the foundation for the method of the study for the following reasons: (1) Glaser and Strauss (1967) identified symbolic interaction theories as having greatly influenced their discovery of grounded theory, (2) Bogdan and Biklin (1982) say symbolic interaction provides a good basis for understanding "shared perspective" and "shared definitions" in groups, and (3) Chinitz and Swanson (1986) in citing the relevance of symbolic interactionism to grounded theory say that knowledge of symbolic interaction helps the investigator to understand behavior as the subject understands it, know their world, understand their interpretations of self in interactions and share their definitions. However, as Bogdan and Biklin (1982:32) point out, "Qualitative researchers tend to be phenomenological in their orientation...", by which they mean that all phenomenologically oriented qualitative researchers approach subjects with the goal of understanding from "their point of view". The phenomenological perspective is compatible with Blumer's
(1969) view that human experience is mediated by interpretation. It therefore becomes the investigator's task to translate the meaning derived from the subject/researchers interactions into the language of the research described.

Glaser and Strauss (1967) defined grounded theory as discovery of theory from data. This research method is particularly useful in areas in which little research is done. Thus, it can be viewed as a precursor to theory testing since the variables relevant to the concepts can be identified, clarified, and described. Grounded theory uses a constant comparative strategy throughout its method. In this strategy, all data are constantly compared with all other data. In this way the investigator is noting the similarities and differences in the experience of those interviewed. Glaser and Strauss (1967) identified five purposes of comparative studies: (a) accurate evidence, (b) empirical generalizations, (c) specifying a concept, (d) verifying theory and (e) generating theory.

**Accurate evidence.** The evidence gained from comparisons is used to generate conceptual categories and then the evidence from which the category emerged is also used to illustrate the concept.

**Empirical generalizations.** Comparative data are used to establish the universality of a fact. For example, do emerging professional nurses know about the American Nurses' Association's Code of Ethics?
Specifying a concept. This purpose is to specify the dimensions of a concept in a one case study. In doing this very detailed description, the investigator is attempting to compare and distinguish his/her case from others.

Verifying theory. This is a major use of constant comparative studies. Some investigators concentrate on verifying the new theory that is emerging from data while others concentrate on existing theories.

Generating theory. The final purpose of constant comparative studies is to develop an explanation or description which accounts for much of the relevant behavior evidenced by data. This is accomplished by generating conceptual categories and their properties and then offering an explanation of how these relate. These are, in fact, the elements of a theory.

Glaser and Strauss (1967) explain how one generates conceptual categories. The process is described in four stages. These are: (1) comparing incidents, (2) integrating categories, (3) delineating, and (4) theory writing.

Comparing incidents. The investigator begins by coding each incident into as many categories as possible. While this coding is taking place, the investigator is constantly comparing each incident with previous ones in the same and different categories. As this process continues, the investigator will eventually find that he or she must begin to record the ideas and reflections that
come to mind as a result of the coding and categorization. At this point, one needs to begin to write memos of these beginning "theoretical considerations".

**Integration of categories.** In the next stage of analysis the investigator finds that he or she is no longer comparing incident with incident but instead is making comparisons of incidents with properties of the category that resulted from initial comparisons of incidents (Glaser and Strauss, 1967: 108).

**Delimiting.** This stage of analysis calls for a reduction of categories by identifying the underlying infirmities in the original set of categories or their properties. In other words, what are some common denominators?

**Theory writing.** The final stage is for the investigator to write the theory. Memos become the theoretical content behind the discussion. Each category should have a number of memos which reflect on its conceptual quality, its relationship to other categories, to extant theory and other research, etc. The categories are the major themes of the findings.

This study incorporated much of the ideas of Glaser and Strauss but also found much of value in the notions of Miles and Huberman (1984). Miles and Huberman believe that data collection needs to be founded and focused for maximum efficiency. By this they mean that the researcher needs to engage in some preliminary pre-analysis in order to reduce data. This position calls for a more deductive
approach to qualitative research than advocated by Glaser and Strauss. For example, Miles and Huberman suggest that the investigator formulate analytic categories out of the research questions. These categories provide a means of classifying the data during the data collection phase which greatly reduces the load during the data analysis phase. They also advise the researcher to write up a contact summary sheet after each data collection episode. This must be differentiated from the reflexive log which is suggested by Bogdan and Bilklen (1982) as a way of avoiding researcher bias.

In blending Glaser and Strauss with Miles and Huberman then the design of this study incorporates both inductive and deductive characteristics.

**Design**

The design of this study was emergent, beginning with a pilot study which was based on a well formulated problem statement. The research questions were roughly worked out and an interview guide had been developed from research questions also in an earlier stage. In other words, the initial approach was inductive. Glaser (1978) provides the following overview of an inductive design:

1. Begin collecting data.
2. Look for key issues, recurrent events, or activities in the data that become categories of focus.
3. Collect data that provide many incidents of the categories of focus with an eye to seeing
the diversity of the dimensions under the categories.

4. Write about the categories you are exploring, attempting to describe and account for all the incidents you have in your data while continually searching for new incidents.

5. Work with the data and emerging model to discover basic social processes and relationships.

6. Engage in sampling, coding, and writing as the analysis focuses on the core categories.

The pilot study was conducted in England in the summer of 1986. The subjects were 12 senior baccalaureate nursing students who volunteered to be interviewed after having given informed consent (see Appendix A). While these subjects were from cultures different from the American population targeted for the main study, this was not viewed as a problem in this case, mainly because nursing has a quality of universality and its code of ethics is an international one, i.e., the Code for Nurses adopted by the International Council of Nurses (ICN) in 1973. The purposes of the pilot study were to appraise the interview guide and the interview process, but in addition to test the potential significance of the research questions. The pilot study not only succeeded in these aims, but in addition, laid a framework for analysis of data in the main study.

Subjects

The sample of the current study consisted of 23 senior baccalaureate nursing students from a total population of
120 who were in their final clinical rotation before graduation. Subjects were all volunteers who gave informed consent after being briefed on the purposes of the study, what would be expected of them, the ways in which their confidentiality would be protected and how they would receive the results of the study.

The choice of subjects was dictated by the nature of the problem. The problem addressed by this study is how emerging professional nurses view their moral accountability to their patients, and further, what influences these nurses perceived had molded their present views. Therefore, senior baccalaureate nursing students were identified as the target population. In addition, it was considered important that these subjects be as close to graduation as possible in order that they be able to perceive their professional role to be in transition. Role transition, i.e., moving from student to professional nurse, is the theme of the Spring Quarter clinical experience at the college from whence these subjects were selected.

Another important characteristic of this group is that all have had a required course in nursing ethics. The focus of this course is on guided analysis of frequently encountered ethical and moral dilemmas in practice settings. Students are expected to be able to distinguish among different ethical theories and use ethical theories as a framework for the analysis of ethical decision-making. This course is placed at the junior level. The
curriculum at this college is planned so that senior nursing students are required to take only one course in spring, their clinical course. In this course students are placed in a clinical setting of their own choosing under the supervision of a clinical expert who works in that setting, therefore for the first time students are not supervised by faculty.

It was the general intention of the investigator that all students in the senior class have an equal chance of being a subject. Therefore, issuing a general invitation to the senior class was considered to be the best way to obtain a sample. The procedure used addressed the total senior class in the second to last week of winter quarter, inform them of the purposes of the study, what would be involved with regard to time, etc., how confidentiality would be handled and how they would benefit from participation. To alleviate any sense of pressure to the individual student who might want to participate, the investigator left the room leaving behind a letter describing the study (see Appendix B) and inviting interested students to contact her if they were interested. This strategy resulted in only ten subjects who were asked to give informed consent in writing. A second strategy was to have individual faculty remind students at the beginning of Spring Quarter that more subjects were needed for the study. This strategy resulted in thirteen more subjects. Appointments were set
up with each subject for an hour long audiotaped interview.

A brief look at the characteristics of the sample would reveal that they very closely represented the total senior class which is made up of a majority of females - approximately 4 percent were male. There is also a wide age range in the class - students ages ranging from twenty-two to the mid forties. A variety of ethnic and racial backgrounds were also represented.

In the sample of 23 subjects, the majority were between the ages of 22 and 25, a few were in their late twenties, at least one was in her early thirties and two were in their forties. Two subjects were men and two were black. Thus, one can see that the sample, albeit voluntary, was an excellent demographic representation of the senior class.

The Pilot Study

The pilot study was conducted in England in 1986. The purpose of the pilot study was to test the interview guide, the interview process and the potential significance of the research questions. The settings chosen were two large metropolitan educational institutions, each offering a baccalaureate in nursing. Permission to solicit subjects had been obtained from each institution early in 1986. The population targeted for study was senior baccalaureate nursing students. However, in one of the settings, it was discovered that the senior
class would have already graduated at the time designated for the study, therefore, the new senior class became the population studied. In the other institution, volunteers were solicited from the graduating class.

At each setting, nursing directors had posted on bulletin boards a request from the investigator for subjects and details about the nature of the study. However in each case, the investigator was invited to speak directly to the students to explain the study and seek questions. A total of fifteen subjects volunteered with three dropping out leaving a final sample of twelve, six from each institution.

Subjects gave informed consent and an appointment was made with each for an audiotaped hour-long interview. At the end of the interview each subject was asked to provide evaluative feedback in writing on the content and process of the interview. The evaluation form (see Appendix E) sought to evaluate the quality of the questions, the subject's affective response to the questioning and the possibility of bias in the investigator's questioning and/or attitude during the interview.

Feedback revealed that subjects felt somewhat threatened by the first question which stated, "What does the term professional values mean to you?" Subjects indicated that they believed sure there must be a correct answer to this question but they were uncertain they knew it. Other feedback revealed that subjects hadn't thought a great deal about the ethical perspective and felt that
maybe they hadn't done a good job in articulating it. Some identified in the evaluation form that they hadn't talked much about the advocate role or confidentiality. Subjects evidenced being somewhat stressed by the questions. One subject said it was very intense. Other subjects said that it was a good opportunity to put their thoughts together on this subject. Three subjects identified a need for greater specificity in the questions, i.e., question too open-ended, too general or too vague. No subject said they had perceived questioning as leading them to particular answers, but one subject, in responding to the question, "How did the questions make you feel?", said, "Happy, because the interviewer gave the impression she shared my beliefs." This led the investigator to re-evaluate her facial expressions and be more aware of its affect on the subjects. Based on the feedback obtained, the interview guide was revised for the major study.

**Instruments**

The Interview Guide. The interview sought to examine three areas of subjects' lives: (1) their internalized self-concept as a function of their role as nursing students, (2) their perception of themselves in this role as viewed through the eyes of their relatives and friends and their view of themselves in this role as viewed through the eyes of society in general; and (3) their patients and professional contacts in particular.
The aim of open interviewing is a guided conversation and for this reason an interview guide provides a plan to follow. Probes are follow-up questions used to help a subject stay focused on the question. An Interview Guide was developed, constructed for the pilot study (see Appendix C) using the first draft research questions as a guide and subsequently modified on the basis of experience in the pilot study (see Appendix D). However, as the investigator discovered in the pilot study, each subject perceived the questions in a unique fashion based on their own definition of professional values and their answers often gave direction for the follow-up questions. The use of probes was often necessary. However, it was also necessary to assure a subject that a particular question may now seem to them to be redundant and that if so they need only answer if they thought they had something to add to prior comments.

The original interview guide began with the question, "What does the term "professional values" mean to you?" Evaluative feedback from the pilot study subjects revealed that this question took them very much by surprise and had a disconcerting effect. As a result in later interviews this question was still asked but softened in its impact to indicate that each subject could clarify the concept as it had meaning for them. They were assured that they could add to their initial definition as the interview proceeded. The result was a more relaxed subject which was more conducive to the aims of the interview. Axelrod
(1976) believes that a subject is likely to be more open in sharing their attitudes when they are relaxed. Benefitting greatly from experiences with the pilot study, the interviews in the major study were much focused and the investigator more relaxed and confident. Since the aim of the interview is to have the subjects express the values and attitudes about the practice of nursing, it was also considered to be of value to summarize for the subjects the important values evidenced in the interview and ask them if there was something they felt had been omitted and if they wished to comment on an area for which no question had been asked. This provided the subject with an opportunity to correct any misunderstanding about their disclosures. In addition it helped them to re-examine their views in order to more accurately present their beliefs. Guba (1981) refers to this strategy as member checks.

The interview guide was used by the investigator to guide the order of questioning and to avoid leaving out a particular question. The process of interviewing, however, cannot be totally covered by a guide since each person is unique, and as a result the relationship with each subject is also unique. There were however, strategies of interviewing which this investigator believed worked very well and these are covered in depth under data collection procedures.

Hypothetical ethical dilemmas. The content of the ethical situations was developed after review of the
literature and in particular the Nurse's Dilemma published by the International Council of Nurses (1973). Two situations were developed each representing a commonly occurring dilemma in the everyday life of a nurse (American Nurses' Association, 1985). Each situation represented a hospital setting and a community setting (see Appendix F). The two situations were selected after consultation with nursing experts representing each setting. These experts were presented with eight possible situations and asked to choose the one which most exemplified a commonly occurring ethical dilemma in their respective setting. All agreed that the two situations selected were not only common but were discussed so frequently in the literature that a format for the analysis of the responses would be, not only easy to find, but be well supported by nurse ethicists.

Clinical Logs. The content of clinical logs is considered to be a rich data source of professional values. Glaser and Strauss (1961) discussed the concept of "slices of data" being the various perspectives which provide differing vantage points from which to understand a particular category. Sevigny (1978) refers to this same notion as "triangulated inquiry". Course objectives direct students to freely express their concerns, frustrations, joys and accomplishments. While the quantity of data contained in logs is considerable the investigator followed the format of Miles and Huberman making "analytic choices" in extracting excerpts from the data which
support the emergent themes and categories. Clinical logs were requisitioned at the end of Spring Quarter after all interviews had been completed. Questions raised by initial data were often resolved by clinical log data.

**Trustworthiness**

The qualitative researcher has a heavy responsibility for the validity of the study. It is a dual responsibility: (1) for trustworthiness in the data gathering, interpretation and reporting of findings, and (2) the responsibility to the subject not to violate confidentiality. Balancing these ideals was not always easy.

The phenomenological qualitative researcher seeks to describe the practical world in terms of what it means to those who reside there. This raises questions about validity and reliability, terms more often associated with quantitative studies. Yet the qualitative investigator is equally concerned about internal validity or the truth value of research.

Concerning the credibility of the researcher, Guba and Lincoln (1982) say that the researcher must strive to describe the reality that exists. In regard to interviewing, the investigator must strive to foster an atmosphere in which the subjects feel free to express their views honestly. Whether the qualitative investigator can capture an individual's intersubjective reality is arguable. It is believed, however, that the
researcher can take certain precautions to improve the trustworthiness of data collection.

In the present study all interviews were audiotaped, to lessen the chance that data be lost. It also provided access to the verbatim words of the subject. Opportunity was provided the subject to validate the data by summarizing important content. Guba (1981) warns the investigator about distorting the data; in particular, he cautions the investigator not to allow a particular relationship between subject and investigator to bias the data. In this study, it is important to note that the researcher is a faculty member in the college from which the sample was selected. This investigator views this as a strength in that interpretation of a subject's perspective depends for a large part on the researcher's knowledge of the social setting from whence the subjects come. In addition, the researcher is familiar with nursing jargon and hospital ways in general. She is qualified to identify a particular situation that needs further clarification or exploration while at the same time being extremely careful not to ask leading questions or to focus on any particular area more than another which might result in bias.

In this study the researcher has made every effort to be conscious of possible biases. One way to handle these was to make every effort not to influence the subject, yet at the same time to "draw the subject out". The investigator was seeking the answer to a series of
questions and could never be totally sure that the questions asked were valid strategies for getting the information which answered the researcher's questions. However, there was a certain amount of security in knowing that whatever mistakes were made, these mistakes were consistent, in that all subjects were asked the same questions. So, one can have confidence that these data reflect how this particular sample responded to this particular set of questions at this particular time. According to Berelson (1952), the traditional position of content analysis is that "regardless of who does the analysis, or when it is done, the same data should be secured under similar conditions". In addition, the investigator must be conscious of the fact that the subject is not always relaxed and may very easily leave out important data if not given sufficient time to reflect. In this study great emphasis was placed on reflection and a strategy used, which one imagines could be likened to psychoanalysis, to help the subject get in touch with their feelings and attitudes. This is explained in detail in the data collection procedure section.

There is a certain amount of concern expressed by some about the validity of subjects' accounts. In other words, how much of what the subject says can be taken to exemplify what they actually believe or what they would actually do in a given situation? Bryder (1981) says it is important to "assess whether an actor says what he
means and conveys what he means in various situations" but he doesn't give any tips on how to do this. Jonsson (1975) says there is no sure way that the researcher can estimate credibility in subjects. Bryder paraphrases Dostijevski as having said some things at the core of every human being that he does not reveal to anyone but his closest friends. He went on to say that there are things he does not even reveal to his friends and finally that there are things which a man (sic) is afraid of revealing even to himself. Axelrod (1976) claims that some useful strategies in "getting at" a person's true beliefs are using source material which is less likely to present an argument and systematically comparing what the person says in different contexts. This view presents the notion that a person is much more likely to be truthful when they do not feel threatened in any way. This idea was a major consideration in putting the subjects at ease during the interviews. In addition, subjects' answers were compared for consistency throughout their interview and with their log data.

With regard to credibility in the interpretation of data the researcher strives to find the meaning intended by the subjects. The findings, therefore, should be such that subjects would find them plausible. The investigator has a responsibility to interpret the larger picture and discern patterns emerging from the data which individual subjects might find surprising. The investigator seeks to find themes in the data which in turn are clustered into
categories. Many of these themes and categories are explained and described in words or phrases used by subjects as they describe their experiences. Making meaning in the overall picture is the task of the qualitative investigator. The investigator can take certain precautions to promote greater confidence in the credibility of findings.

Atwood et al. describes a process by which a panel of experts are asked to evaluate how well data bits, i.e., subjects' own words, fit under the categories chosen. For example, is there is a sufficiently strong relationship among the data bits to warrant their classification under a particular category? This investigator sought such expert opinion among nursing colleagues who not only work with students in hospitals but who also specialize in nursing ethics. These experts reviewed the analyzed data for category "fit" and made suggestions for minor changes. Finally, since all interviews were audiotaped, an "audit trail" was possible, i.e., making data from interviews and clinical logs available to an external auditor who could more objectively review the evidence from which conclusions were drawn. An audit trail was not done.

Limitations

The investigator's own professional values is a potential limitation. Caution needs to be exercised during interviews not to lead subjects in a particular
path or by facial expressions or gestures to indicate approval or disapproval of subject views, perceptions or beliefs. One way to lessen this limitation is to be conscious of own mannerisms and make a concentrated effort to be non-commital.

Another possibility of limitations is that as indicated earlier there currently exists a relationship between the investigator and the subjects. In fact, all potential subjects have been the investigator's students in a classroom setting. The concern that the subjects might be intimidated by the investigator is valid. However, the data collection phase took in the last quarter of the subjects' senior year and at a time when most students are less likely to be reactive about instructors prior evaluations of their clinical and classroom performance. A possibility also exists that students might see the investigator as a sounding board and exaggerate or embellish their experiences.

The fact that subjects were all volunteers who self-selected for the study can be viewed as a limitation since it is possible to conceive that the sample had characteristics not representative of the total population.

The possibility that subjects' professional values undergo a change as a result of the interview is yet another limitation. This phenomenon, known as reactivity or Hawthorne Effect is always a possibility in a two-stage study such as this (Guba and Lincoln, 1982). For example, it is possible that as subjects reviewed their thoughts on
professional values and ethics, they became more conscious of these behaviors and therefore changed their behavior which may have been reflected in the clinical logs. Another possibility is that because they became more concerned with professional values because they were being studied, they would provide their instructor with evidence of this in logs but not have evidence of this in practice. These are all concerns of the naturalistic investigator yet very little can be done about this except to be aware of their possibility. One factor to consider is that students began their logs on the first day of their clinical experience and the subjects were not interviewed until several weeks into the quarter. In fact, some subjects were not interviewed until the end of the quarter. Thus, it was possible for the investigator to be alert to any change in the logs which might have been related to the interview.

The universality of qualitative studies is often considered a limitation by many. The extent to which findings from this study can be applied to other similar settings depends a great deal on the context of the generalization and to what extent the contexts are similar. Guba (1982) makes the point that the qualitative investigator does not attempt to form generalizations that hold in all times and in all places but to form a working hypotheses that may be transferred from one context to another depending on the degree of "fit" between the contexts. Another important point that needs to be made is that groups may perceive that a particular finding may
be applicable to their experience, i.e., nursing students who may say "yes, I can identify with that", likewise, nursing educators may find valuable insight in the findings even though certain characteristics of the population are not similar.

Data Collection Procedure

Data were collected in three ways. First, subjects were interviewed according to an open interview guide. Second, subjects were asked to respond orally to a hypothetical ethical dilemma in the interview. Finally, subjects' clinical logs were subjected to content analysis.

On the day of the interview for each subject, the subject was greeted and offered a soft drink or cup of coffee. The interviews took place in an empty office for two reasons: (1) the investigator thought it important to conduct the interviews in a neutral zone, i.e., not in her own office, and (2) the empty office had no phone, thus minimizing chance of interruption.

Prior to turning on the audiotape, the investigator did four things. First, the subject was reminded of the purposes of the study, secondly the subject was asked to try to forget that the investigator was an instructor but to focus instead on her role as investigator. The subject was told that one of the reasons they should do this was so that they could feel perfectly free to be honest in their remarks, even if their remarks were in any way
critical of the school or its faculty. Thirdly, the subject was oriented to the nature of the interview and informed that it was the investigator's job to seek answers to the questions but not to respond in an evaluative way to the answers, i.e., the investigator would be noncommittal using such tactics as "yes", "I understand what you are saying", "Um Humm", etc. It was decided that alerting the subject in advance would set them at ease so that they would not look to the investigator for approval of their views. Also, it was thought that the clarification of roles was an essential part of the interview relationship. Finally, the subject was asked to select a code name would be used from that point forward for the identification of their data. At this point the investigator turned on the tape and the interview began.

Having the subject express his or her values about nursing is not as straightforward as it might seem. Naturally, one wishes to know how to achieve this aim. According to Goffman (1959), one tend to "manage" the impressions that others receive of one. This is the reason underlying the investigator's apprehension that the subjects would experience what the pilot study evidenced, that is, subjects becoming extremely concerned about "doing well". This concern may then distract them from getting in touch with their true feelings and values or to present themselves to the investigator as students to an instructor demonstrating their learned views on
ethics, not necessarily their lived experiences in ethical practice. In other words, the investigator wished to avoid receiving the "correct" answer instead of the valid answer.

Since the aim of the study was to have the subject express their views on ethical nursing. In order to avoid an a priori fallacy, the investigator had each subject define the concept as it had meaning for him or her. The strategy chosen was to avoid the use of the word "ethics" in the early part of the interview. The reasoning was that the subject would then "tune in" to an expected mind set. Therefore, the first question called for the subject to define the term "professional values" using any words or phrases which might best illustrate the concept. The next question asked if the subject was aware of any formal guidelines which the profession made available to its membership offering guidance in the area of conduct. Thus, an attempt is made not to set the stage for the subject. The third question was an attempt to reveal the subject's own values and once again the investigator was attempting to uncover what the subject really believes about nursing ethics without using the term ethics. So, the investigator asked the subject to think in a critical way about nursing as they had experienced it. Then, tell the investigator what they considered examples of "good" nursing and what were examples of "bad" nursing. In each case, subjects were told that "good" nursing should represent the way in which they believed nursing ought to
be done and "bad" nursing represented the way in which they believed nursing ought not to be done. The revelations which followed represented the bulk of the data.

A subsequent question was aimed at discovering the kind of nurse the subject believed himself or herself to be. In attempting to discover the answer to this question, the investigator asked the subject, not only to reflect on the kind of nurse that they believed themselves to be, but to step inside the shoes of their patients or colleagues and pretend that they were eavesdropping as these significant people responded to the same question about them. Some subjects reported feeling briefly uncomfortable with this question but did not avoid it nor elaborate on why they felt so. The investigator took this as a sign that the subject was indeed getting in touch with areas they had not thought of much in the past. After subjects had discussed the kind of nurse they believed themselves to be, they were then asked to discuss the forces most influential in their becoming the nurse they believed themselves to be. The next question was aimed at discovering how they perceived that they were implementing a code of ethics in their everyday practice. Since it was suspected that subjects would again become concerned about the "right" answer rather than their actual lived experience, the investigator began this question with a brief summary of values identified by the subject earlier in the interview. The purpose of this was
to not only make the subject aware that the investigator had been listening, but also to provide the subject with an opportunity to correct any false impressions or add something new in their answer.

In attempting to uncover how these subjects perceived nurses in general, the investigator told the subjects that she wanted them to evaluate how nurses in general met their standard. It was reiterated at this point, by the investigator, that the standard by which the subject judged his/her professional colleagues was the one which he or she had been describing throughout the interview - their own standard.

In order to have the subjects comment on how they perceived their future as ethical practitioners, the investigator began as follows:

You are now in a position in which you can look into the future and have a good idea of what your professional experience will be. I'd like you to tell me how you perceive that? What are your chances of practicing nursing the way you believe it ought to be done?

Finally, the subjects were given the opportunity to discuss anything they had thought of during the interview but had not been asked a question about. At the end of this interview, the investigator briefly summarized again and asked the subjects if they believed their values had been adequately presented and if there was anything further they wished to add. They were then asked to select the value which was so important to them they would be unable to practice nursing without it. This ended the
interview portion of data collection and preceded the reading of the hypothetical ethical dilemma.

The Use of the hypothetical Ethical Dilemma

The procedure for seeking the subjects' responses to the hypothetical ethical dilemmas was this. The two dilemmas were accorded an odd/even code and depending upon which number of interview was being conducted, the appropriate ethical dilemma was selected. Prior to reading the dilemma, the subject was told that the researcher would read a hypothetical situation, and that no one could ever be sure how they will act in any situation until they are actually faced with it, but that the subject should attempt to place themselves in the situation, identify with the nurse in the situation and then respond as they believe they would act in that same situation. The interview was terminated when the subject had responded to the ethical dilemma but before each left they were reminded of the need to obtain the clinical logs at the end of the quarter.

Clinical logs

The process for collection of clinical logs called for subjects to bring them to the investigator at the end of the quarter. Of the 23 subjects, two had not made use of clinical logs as a learning experience and in addition, one log was lost at the end of the quarter. In all of these cases, the subjects had already completed the interview before the investigator was aware that there would be no log and it seemed that the lack of three logs was not a major factor in the total study. When the
twenty logs were received these were also coded with the same code name chosen by the subject during the interview. These names were available to the investigator on the tape and she had a numerical list of when each subject was interviewed. Being able to compare a subject's interview data with data from logs was considered important, not only from the perspective of data, but from the perspective of validity corroboration.

Procedure for Data Analysis Miles and Huberman (1984) believe that the data analysis begins in the data collection phase. In order for this to occur the investigator needs to have already identified certain analytic categories which are used for the classification of data as it emerges. Again, one needs to clarify that these preanalytic categories are not the same as the categories referred to by Glaser and Strauss which emerge from the data.

The analytic categories pre-selected in this study were extracted from the research questions. These are:

-- Words and phrases by which subjects construe professional values

-- Anecdotal examples of students' professional values

-- Students' own words describing the kind of nurse they perceive themselves to be

-- Influences which molded present views

-- Perception of how other professionals accede to code of ethics (previously defined by the subject)
— Students' evaluation of preparedness to practice nursing according to one's own standards

— Students' perception of freedom to act in accordance with own ethical code

— Response to hypothetical ethical dilemma

These categories formed the foundation for data classification which was most helpful in the beginning when the data appeared totally overwhelming.

One of the first tasks was, of course, to have the audiotapes transcribed. When this task was done the investigator began the task of listening to each tape and making appropriate corrections in the transcriptions. At this point the investigator resisted writing in the margins but instead made notes on index cards which were then appended to these transcripts. These cards formed the initial coding of the data. When this initial task was completed all transcripts were copied and each page of data was numbered from line one to line twenty-four which was the usual number of lines on a page. This was considered to be valuable for quick retrieval of a particular subject's data.

At this point, several themes were emerging from the data yet the investigator felt very anxious not to underestimate the significance of familiar concepts in the data. The transcripts were put away for awhile and the investigator began reading the logs.

Analysis of the logs was conducted in much the same way as the transcripts. The investigator read each log
and made notes on an index card which was then appended to the log. At first, the reading of the logs took place independent of the subjects' transcript and eventually the index cards were compared and, in most cases, the data re-read for additional confirmation of findings.

The researcher's perceptions, thoughts and ideas were then recorded. This was the first step in the process which Glaser and Strauss call "memoing". These memos, at first, were simple phrases such as "log corroborates interview" or "she seems to have had a mind change about that", or brief exclamations about logs being "task-oriented". Some logs were written in the form of, "I did this then I did that". Each day, logs recounted how the student had passed a catheter, started an I.V., suctioned a patient etc., etc, while other logs were written in the format of a diary and were "feelings" oriented. These notes also helped the researcher to be aware of her own biases and be cautious of placing too much emphasis on the format of the logs since very frequently, this was a reflection of the instructor preferences.

At this particular point in data analysis, the investigator began to write notes to herself regarding her concerns, ideas and reflections on what was emerging from the data. A great deal of stress was being experienced and an overwhelming sense of responsibility for accuracy of interpretation. It was time for another respite. The investigator turned, at this point, to the literature once again. Fortunately, it seemed as if there had been
massive proliferation in the area of ethical inquiry since the beginning of this study, so there was much to read. As reading proceeded notes were made when a question arose or something particularly related to the present study appeared. Eventually, the data were approached again and this time the answers to all interview questions were painstakingly recorded in such a way that they could be compared within the sample. From this process the categories began to emerge. As the categories emerged, and were gradually reduced to two main themes, these were then set up as criteria and the data screened for data that did not fit these two themes.

The next step in data analysis was to subject the two major themes found in the data to the scrutiny of nursing experts and seek their feedback on the data "bits" seeming to support these themes.

The final step in data analysis was to analyze the responses to the ethical situations. This was approached by formulating a brief solution to each dilemma by which subjects' responses could be evaluated. The first ethical situation was as follows:

You are a community health nurse and you have just picked up several new cases due to the temporary absence of a colleague. Very soon you become aware of gross negligence on the part of this nurse. For example, you find a situation in which child abuse is evident yet has not been reported and in another case you find an insulin dependent diabetic whose blood sugars have been extremely high with no intervention.
In this situation nursing negligence is quite clear and the ANA Code for Nurses explicitly states that the nurse has a moral obligation to protect the patient from incompetence (ANA Code for Nurses, 1976). What it means in the above situation is that the nurse must not only correct the situation that has been neglected, but make quite sure the nurse in question does not continue to endanger patients. The best action the nurse could take is to confront the nurse in question and find out what the problem was and make clear that, the nurse and her actions would be reported to the proper authority. (The Code with Interpretive Statements, 1985).

The second ethical situation was as follows:

You are a hospital nurse and one of your patients has had an exploratory laparotomy and CA of the colon was diagnosed. While the patient was still asleep the doctor spoke to his family who requested that he not be told. The doctor agreed to this and puts this on the record. Several days later the patient tells you how lucky he was and he was afraid he had cancer.

This situation is not quite as straightforward but it involves the ethical principle of veracity. This situation is a clear-cut case of deception even though the deception in this case is considered to be in the best interest of the patient. It also involves paternalism when others believe that they know best for someone. The best course of action for the nurse in this case would be to use therapeutic communication and "draw the patient out". What has the doctor told him? Does he perhaps suspect that he is not being told the truth? The second
step would be to speak to the physician, voice concerns about the situation and finally speak to the family. If all these actions result in the conviction that this person would benefit and not be harmed by this knowledge, then the nurse has a moral obligation to tell him (Fromer, 1981; Bandman and Bandman, 1985; and Yarling, 1978).

Summary

In this chapter the salient issues surrounding qualitative method were discussed with special emphasis placed on grounded theory. The design of the study was partly inductive as per Glaser and Strauss and partly deductive according to Miles and Huberman. Sampling was voluntary and the characteristics of subjects were outlined. Data were collected in three ways, through audioted interviews, responses to a hypothetical ethical situation and subjects' logs. Content analysis was conducted on all data. The identification of pre-selected analytic categories were useful initially to help the researcher focus on the data which was relevant to a particular research question. In most respects the analytic categories are an effective way to bind and focus the data thereby allowing the researcher to begin analysis in a preliminary way. A detailed discussion of the procedure for data collection and analysis was provided. The results of the study are presented in Chapter 4.
CHAPTER IV
RESULTS OF THE STUDY

Introduction
One of the most difficult challenges a qualitative research investigator faces is in presenting the findings. Literature reveals great diversity in this area. Lofland (1974) discusses several styles of presentation. Bogdon and Biklen (1981) say that styles of presenting the findings can be thought of on a continuum. At one end of the continuum is the more formal way of organizing the presentation and on the other is the more non-traditional modes of writing. Yet, while diversity has always been encouraged, the investigator is never released from the obligation of providing the evidence which supports the interpretations. Lofland (1974) believes that interpretation without sufficient evidence is not always necessarily attributed to dishonesty. It may instead be related to time pressure or effort in abstracting from the data the many incidents supportive of the findings. The researcher already familiar with these data, may decide to provide "general characterizations" of the anecdotal
episodes in the data in order to save time and energy.

Lofland quotes Blumer on this particular issue:

Most of the improper use of the concept in science comes when the concept is set apart from the world of experience, when it is divorced from the perception from which it has arisen and into which ordinarily ties. Detached from the experience which brought it into existence, it is almost certain to become indefinite and metaphysical. I have always admired a famous statement of Kant which really defines the character of the concept and indicates its limitations. Kant said brilliantly, "Perception without conception is blind; conception without perception is empty." (Blumer, 1969:168)

Interpretation is a concept not well described in the research literature. It would appear that those who have done it successfully are unaware of the need to describe the process. Interpretation must be differentiated from analysis. Analysis is a process which has been well described by Glaser and Strauss and Miles and Huberman, and is the process of identifying the themes and categories which form the essence of the theory. However, interpretation is the process of "making meaning". Glaser and Strauss (1967) speak of the memoing process which one understands to be interpretation. In the presentation of the findings of this study the investigator will interpret the results by asking herself the following questions: What do subjects mean by what they say? and, Is there a meaning in these data not easily understood by the average reader? Through this process the investigator attempts to walk the thin line between what is interpretation and what is discussion of the findings.
In this study, the data relevant to the concepts are presented in the subjects' own words in the text and the appendices. In the text, excerpts are chosen which best illustrate the concept under discussion.

Presenting the results of qualitative research, in particular grounded theory, has been subjected to much discussion in recent times. Some authors believe that the very nature of grounded theory entails a serendipitous outcome which eliminates the purpose of the original research questions in the presentation of results (Munhill and Oiler, 1986). Leininger (1985) believes that original purpose and research questions provide structure to qualitative studies and are necessary.

In this study, the research question provided this investigator with a focus, a beacon of sorts, which kept her from deviating from the purpose of the study. This study is centrally concerned with how senior baccalaureate nursing students perceive their ethical role, what they perceive ethical nursing to be, and their evaluation of ethical practice among health care colleagues. The results are presented in the order of the research questions which are as follows:

1. How do senior baccalaureate nursing students construe the term professional values?

2. How do senior baccalaureate nursing students describe their perception of a commitment to professional ethics in nursing practice?

3. What do senior baccalaureate nursing students describe as the influences which have resulted in their present views in regard to professional ethics?
4. How do senior baccalaureate nursing students evaluate their future as ethical practitioners?

5. How do senior baccalaureate nursing students judge the ethical performances of nurses in general?

6. How do senior baccalaureate nursing students perceive that they are implementing an ethical code?

7. How do senior baccalaureate nursing students respond to a hypothetical ethical dilemma?

The Results

Research Question 1  The first research question is concerned with how these subjects construe the term "professional values". The results in subjects' own words are presented in Table 2. The answers, in terms of the words used, revealed that the words "honest" or "honesty" and "professional" or "professionalism" were used most often with each concept alluded to five times. The next commonly used words were "caring" and "accountability" each used four times. After that, the words "responsibility" and "standards" were used three times. In terms of underlying ideas, one can surmise that the main focus of the answers to be the quality of patient care and the qualities of persons providing care.

What do subjects mean by such terms as "professionalism", "professional manner", "quality of care", and "accountability"? It would appear that the subjects who used the term "professionalism" and "professional" were thinking of such things as education, knowledge competence, etc. This is evident because of the
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>PROFESSIONAL VALUES</th>
</tr>
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<tbody>
<tr>
<td>E.A.</td>
<td>Respect for the individual and being non-judgmental</td>
</tr>
<tr>
<td>L.B.</td>
<td>Health and caring</td>
</tr>
<tr>
<td>A.C.</td>
<td>Professionalism, i.e., education, etc.</td>
</tr>
<tr>
<td>R.D.</td>
<td>Standards of patient care</td>
</tr>
<tr>
<td>J.E.</td>
<td>Overall patient safety and professional in manner and dress</td>
</tr>
<tr>
<td>K.F.</td>
<td>Trust and confidentiality</td>
</tr>
<tr>
<td>H.G.</td>
<td>Honesty, responsibility, accountability, and caring</td>
</tr>
<tr>
<td>J.H.</td>
<td>Accountability, responsibility, pride in nursing profession and in the organization</td>
</tr>
<tr>
<td>M.I.</td>
<td>Health promotion and maintenance and collaboration</td>
</tr>
<tr>
<td>V.J.</td>
<td>Quality of care, caring in general</td>
</tr>
<tr>
<td>J.K.</td>
<td>Quality of care and collaboration</td>
</tr>
<tr>
<td>S.L.</td>
<td>Education and professionalism</td>
</tr>
<tr>
<td>A.M.</td>
<td>Honesty, integrity, responsibility, good documentation, and continuing education</td>
</tr>
<tr>
<td>S.N.</td>
<td>[Generalized not concrete]</td>
</tr>
<tr>
<td>N.O.</td>
<td>Evolving not well delineated - knowledge and expertise</td>
</tr>
<tr>
<td>K.F.</td>
<td>Respect and congeniality</td>
</tr>
<tr>
<td>D.Q.</td>
<td>Having a professional manner in dress and behavior and standing up for things you believe in</td>
</tr>
<tr>
<td>S.R.</td>
<td>Professionalism, individualized quality of care, education and skills</td>
</tr>
<tr>
<td>P.S.</td>
<td>Autonomy, accountability, standards of practice</td>
</tr>
<tr>
<td>L.T.</td>
<td>Good patient care, honesty and accountability</td>
</tr>
<tr>
<td>L.U.</td>
<td>Standards according to ideal values</td>
</tr>
<tr>
<td>F.V.</td>
<td>Integrity, honesty and belief in yourself</td>
</tr>
<tr>
<td>F.W.</td>
<td>Being honest, conscientious, competent and caring</td>
</tr>
</tbody>
</table>
linkage of these concepts with the term professionalism when it appears. Obviously the subject was concentrating on a definition for "professional values" with emphasis on "professional".

Others appeared to "step over" the broad connotation of "professionalism" and think specifically of the nursing profession. Such terms as "quality of care", "standards of care" "accountability" and "caring" are germane to their everyday language in nursing. Accountability and responsibility are integral to nursing jargon. Accountability to a nurse means being answerable for one's actions. Accountability is not only holding oneself responsible for how to complete a task correctly but, in addition, accepting the responsibility of being held accountable for decisions and judgments made in the course of practice. The essence of accountability and responsibility is knowledge, knowledge not only of one's art and science, but of one's limitations. A review of the ANA Code for Nurses will reveal that tenets #4, 5, and 6 speak to accountability, responsibility and competence.

Research Question 2 The answer to research question number two which states: "How do senior baccalaureate nursing students describe their perception of a commitment to professional ethics in nursing practice?" forms the largest portion of the data and is central to the purpose of this study. The reader may recall that subjects were asked to describe what "good" nursing was or how nursing ought to be done. In addition, they were called upon to
describe what "bad" nursing was or how nursing ought not be done. The responses to this question reveal a portrait of nursing in the spirit of Nightingale's work (1969), "Nursing - What it is and what it is not."

In describing nursing as they believe it ought to be, these nursing students perceived respect for persons to be the most basic ethic. In addition, they perceived that nursing was caring. The concept of "respect" is presented first and is interpreted through the words of the subject and through appropriate literature sources.

Respect

Respect for persons as a subject for moral philosophy has been discussed by ethicists for centuries. Downie and Telfer (1970) say with regard to respect for persons "... not only is it the paramount moral attitude but all other moral principles are to be explained in terms of it". Subjects perceived that nurses ought to respect patients and families themselves, their colleagues and their profession. Data relating to respect for patients and families will be presented first.

Respect for Patients and Families

In describing the primacy of respect as an ethic for nurses, one student said:

The American Hospital Association also has published Patient's Rights. They all seem to flow from a respect for the human dignity and uniqueness of the client. (E.A., log 1.2)

I think along with the respect for the client involved, I think that nurses that I have observed tend to find the family somewhat of a burden and I think that in and of itself is a
real problem. I think if you are warm and empathetic with the family you can gain their support. (J.E., interview b.22).

The dimensions of respect for patients and families can be understood further in the following excerpts:

Things that I think are good are respecting the patient's rights. I think that is in any area. Last quarter I was in the psych [sic] setting there were people that refused to take their psych drugs and it was very well accepted there. (J.E., interview 2.9)

I really value as a nurse supporting the independence of patients as much as possible and really kind of bending over backwards to let them do for themselves whatever they can do, which is hard to do a lot of times in the institutional setting, because it means giving up a certain amount of control and the nurse a feeling of power and not being rigid about adhering to hospital routines where there is no medical reason to do so, like can the patient put on street clothes, can the patient have a snack other than the prescribed snack time, and these kind of things. (L.B., interview 2.7)

The dimensions or components of respect appear to fall into three major themes. These are: (1) respect for the human dignity and uniqueness of the patient; (2) patient autonomy or self-determination, and (3) acceptance of the patient's values even when the nurse and health care team disagree in terms of treatment or lifestyle.

How does the nurse provide respect for the human dignity of persons? Subjects described respect in terms of what the "ideal" nurse would do:

The first nurse was ideal. She came in and she listened to whatever the patient had to say to her. Even though, she didn't understand it, she'd say "I didn't understand that please speak slower so that I can understand what you are saying to me." She was candid on the phone with the family. She gave her respect by pulling curtains when some procedure had to be done. She
always explained from beginning to end before she was doing it and while she was doing it. (N.O., interview, 2.20)

The one thing that comes to mind is my preceptor. She has been a good role model. Just the way she would talk to the patients. She would treat them like human beings and encourage them especially in labor and delivery where they need a lot of support and encouragement. It was not just what she said but how she said it. (L.U., interview, 1.7)

I think being willing to spend the time to listen when the patient should want to talk is very important. Sometimes that can work better than any medication you give them (J.E., interview 2.3).

Trying to let those people ventilate what they are feeling and seeing that, when they ventilate, you can see solutions to their problems. To make what they are going through at this time, easier and make the whole experience not be so negative, and not be so pressure packed as it probably can be. I think by being honest with people when they ask you questions is another important thing. You have to do it within a certain scope and you have to know your bounds and the situations dictate that but I think in all situations you have to be as honest as you can be. (H.G., interview, 2.14)

Subjects appear to be saying that respect is evidenced in the manner of interaction with the patient, i.e., listening, being honest, candid and "treating them like human beings". The importance of respect then for these subjects was the message conveyed to the patient in the initial interaction, i.e., recognizing the patient as a person.

Kelly (1976) says, "the true ethics of all health care codes are based on the rights and dignity of individuals - treating the patient as a person". Curtin (Curtin and Flaherty, 1982:3) has consistently pointed out that ethics
in nursing is more evidenced by the day-to-day activities among nurses and patients than "fabulous life and death issues". She goes on to discuss a case study which she says represents the "daily disrespect to which patients are subject". These nursing students were very conscious of the "daily disrespect" to which Curtin refers. The following data represent how subjects perceived that patients ought not be treated:

The first thing that comes to mind...that really makes me angry is the nurses that don't listen to the patients. They go in the room and they want to hear a certain thing and no matter what the patient says that is the way they come out. Recently I found that is the case even with really good nurses. In other areas for some reason they are just busy, or they are hung up on something else, or they intend to ignore what the patient is saying to them (J.E., interview 1.15).

One thing that I hate that I saw at work is like, if you have an older patient who is always on the call light and always wanting something moved, the nurses don't go in there--they just look at them as a pain or the person wants attention--they just ignore them, they will let their light on for a half hour before they go in and check on them. Then you have nurses who are real nice and go in and be smiling and be up to it (S.R., interview, 1.5).

When doctors come in for rounds and they talk over the patient, they don't talk to the patient, they just talk to each other...but then the nurse is usually there with rounds and when she doesn't go back and explain to the patient what was said so the patient understands. That bothers me... (V.J., interview 1.9).

They (doctors) don't treat the patient with dignity. They overlook them as a person. They just treat them like a machine that is not functioning and they have to fix it. I had a female patient and she has cancer and they didn't even tell her. They just talked over her..."I think she has cancer", and the lady is sitting there and she says "I have cancer" and nobody ever told her. Her brother died and they just
walked in like nothing happened. They didn't talk to her at all. They just talked right over her. They scheduled things and they didn't even tell her why (V.J., interview, 2.10).

In addition to the previously described concept of listening to the patient, the subjects here have described how nurses and physicians ignore the patients. They act toward the patients as if they don't exist or as Sartre says, as "things". Marcel (1981) says to be talked at by people for whom one does not exist throws one back on oneself. One becomes objectified as a case instead of a person, a type instead of an individual (Noddings, 1984).

Another concern identified by these students was the manner in which patients were addressed:

Instead of calling the patient by their name, they—a lot of nurses—call the patients by their first name or they call them "honey". I work with a lot of older patients and I don't like that belittling. I think we should show respect. I wouldn't call my grandmother "honey"! I wouldn't call anyone older then me "honey". I hate it when people do it to me (K.P. interview, 6.25).

By far the more serious form of disrespect in patient interactions was evidence of frank verbal abuse and an illusion to physiological abuse.

As we finished cleaning the perenium the nurse went ahead and powdered the perineum and the powder was getting in to the trachial tube and it was irritating. The patient was smacking her lips and trying to get the nurse's attention that this was bothering her and the nurse said, "you think that smells you ought to smell this between your legs you got a yeast infection going." This gave the patient even a lower self-esteem. (N.O., interview 2.15)

...then he was dreaming again and she just pulled on the restraints hard and said"No!!" and I was like looking at her and I was just shocked. I
couldn't believe she would talk in that kind of voice to someone. It was like she was talking to a dog. She talked like that right over the patient. She said "when you work in a nursing home you have to treat them like that or they won't mind". (L.U., interview 2.2)

I have seen nurses who are like a sergeant. They come in and say, "look what we have done, made the bed wet again. You pulled your catheter off again and I have to clean up the bed again." (S.L., interview 1.21)

I think broadly speaking just nurses not seeming to care about their patients or not being able to demonstrate that they do, sitting in the nurse's station ignoring requests for assistance in their direct or service covert just seeming to ascribe very negative motivation to their them, making trouble and things like that. (L.B., interview 5.16)

Sitting at the nurses station talking about patients, ascribing negative motivation to patients was a form of disrespect that was particularly painful to these nursing students. There were several references to "talking about patients."

In the first instance I was assigned a new admit whose reputation preceded her. F.B. is an 88 year old, bright, talented woman with metastatic breast cancer and back pain. She was admitted for her back pain. She has been at the hospital in the past and was effectively evicted, probably by unanimous decision. She didn't come in until late at night and her "coming" was talked about all evening. (E.A., log 2.15)

The worst thing was listening to other staff saying she was "a hopeless case, maybe she'll stroke out", and "oh, isn't she a pity". (V.J., interview 2.16)

Evening shifts are quite different from day. More talking and opinion sharing goes on than does on days. On Wednesday evening I cared for three patients, all 80 years and older. As the night shift came on, the talk turned to this man. His night nurse found him in the bathroom (not such an unusual event, considering that he is allowed to be up and about).
"What's with 29, he's running around the hospital?"
"He's probably confused."
I contributed that I hadn't found him confused at all.
"You know, they get more confused at night. I don't think there's a full moon."
I went down to check. He was merely using the bathroom. On a unit that handles such a high proportion of geriatric patients I would expect less prejudice. (E.A., log 3.2)

Talking about the patient in surgery was also cited:

The first time I went to a surgery, I could not believe that this person was opened up abdominally. The nurse happened to say to the doctor, leaving that open like that, all that gas and air getting in, the patients is going to be experiencing a lot of cramping the next day. He made some obscene remark about how he would pass this gas and he laughed. This man's pain the next day was of no concern to the physician although the nurse was very forthright in saying that but nothing was done. (E.A., interview 2.10)

A form of disrespect which the students called "labelling" was described as follows:

If the patient asks for something that the nurse has not thought of providing then that patient was termed manipulative and discussed in the conference room as such and enjoyed that reputation. One patient said that he wanted to have a footboard because he was always very uncomfortable lying in bed after a hospital stay and he just wanted this board at the bottom of his feet. It seemed like a reasonable request but it brought on all these charges of being manipulative. (E.A., log 3.19)

I think every time I am there, I hear the labelling. It is so hard not to really get involved in the labelling. (V.J., interview 2.14)

In these excerpts one is struck by the pain, the disillusionment and the anger experienced by these nursing students. Can one blame them if they wonder how many of these nurses were educated or what has occurred to change
their attitudes? Yet, it appeared as though they rationalized that many nurses were simple "burned out" and should not be practicing nursing any longer. The following excerpts illustrates these points of view:

There are so many nurses that are burned out and they are just there. (V.J., interview 2.15)

I think nerves begin to go when people get tired. They are only human...hazzling with the doctors, worrying about patients, it might be that they get a little short -- a little sloppy. (J.E., interview 4.13)

I have seen... people who have been nurses for years and years.... They are just burned out or they have been doing this for so long it becomes a ritual. (J.E., interview 4.11)

Self-determination of Clients

Philosophers specializing in ethics Downie and Telfer (1970:28) describe the components of respect for persons:

In so far as persons are thought of as self-determining agents who pursue objects of interest to themselves we respect them by showing active sympathy with them; in Kant's language, we make their ends our own. In so far as persons are thought of as rule-following we respect them by taking seriously the fact that the rules by which they guide their conduct constitute reasons for which may apply both to them and to ourselves...These two components are independently necessary and jointly sufficient to constitute the attitude of respect which it is fitting to direct at persons...

This view of respect for persons places emphasis on autonomy or self-determination and acceptance of personal values. In the following excerpts from data, subjects describe self-determination:

Explaining the procedures before you attempt them on a patient. That, certainly is alerting that patient what is being done, by supplying them with all the information they
valid decision about a test or procedure whatever that you will be doing. Just simply to me looking out for their best interest on a daily basis (J.E., interview 2.9).

I guess I have a real strong feeling about a terminal ill patient being able to decide that now is the time that I would like to die. I think I would find it very difficult to have a patient that wanted to do that and I would not be able to help him do that (F.U., interview 3.18).

It was very difficult for the physician because she was trying to tell the parents the different things that she could do but she could not say how long the child would live...She said honestly, "it could be anywhere from six months"...I think the delivery of the physician when she presented them with all the information was absolutely wonderful...when they finally made their decision they were confident they made the right one. Knowing that they had options to choose from (J.H. interview 10.20).

One would be keeping the family informed. The respect for older persons. There are a lot of patients who come back and the nurses say he won't take his medication. You feel like you are working to no avail. When doctors order tests or procedures - do they really have to be done. When a patient is not informed of the side effects of a drug or about this test - will it be painful or not. They don't tell them anything about their medications and then they (the patients) are really upset about it (K.P., interview 2.13).

The concept of self-determination for clients is discussed by the ANA Code for Nurses with Interpretative Statements (1985). It states that "whenever possible clients should be fully involved in the planning and implementation of their own health care". It goes on to state that each client has a right to determine what will be done with his or her person; to be given information with which to make an informed decision, to be told the effects of care and to accept, refuse or terminate
treatment. The subjects in this sample were aware of these rights as evident from the following data:

What I didn't like about the medical student delivering the baby the first night was; She wasn't given a choice. He just stepped in and did it... (L.U., log 3.18)

The few times that I have heard procedures explained, surgeries explained, they mumbled, they gave minimum facts. Said to the patient, do you understand this and the patient responded yes, didn't ask questions and was very passive. "Whatever you say, doctor." That is how I viewed physicians. I don't think patients in a sick role are astute enough to speak up with questions. (J.E., interview 5.10)

I have heard patients talked down to. With children, not just doing things explaining if it's a four year old child maybe they won’t understand everything that this is for, but you have got to tell them what you are doing. Sometimes they (the nurses) are in a rush. (A.C., interview 2.6)

An EEG revealed only spurts of activity and a CT scan showed undifferentiated white and gray matter in the brain. TK's doctor told the family he expected a full recovery (this from a nurse who was with the family when they were told). The nurses were furious! The next day another doctor told the family what all the tests had revealed and that TK would probably never recover. Of course the parents didn't want to believe the second doctor, told the nurses he had "lied" to them. All that night they kept asking the nurse caring for TK "when will he open his eyes?" "When will his temperature come up?" "When will he start responding?" The nurse was so frustrated that she couldn't be truthful with the family and kept answering them, "I don't know." (F.V., log 4.2)

When he came in they did an exoneration, they took off half of his face. His nose was hanging out in mid-air. He basically lost half of his face. He did not, in my perception, he did not want the surgery. He said, "Is there any other way?" There were no other alternatives offered to this man. He went ahead and consented to the surgery... (S.L., interview 3.17)
There appears to be no doubt that these nursing students were aware of what constituted violations to personal rights and though they were never asked specifically in the interview about the Code for Nurses, appeared to be making ethical decisions based on its first ethical injunction. It also appeared that these students felt a sense of failure to act ethically when they perceived that they had either participated in an abuse of rights or at least had not said something.

I've already mentioned my shortcomings as an advocate, as well as my perception of the reasons for this deficiency. Also, I feel relatively powerless next to transplant doctors (R.D., log 4.6)

For example, I had a patient that needed an NG tube passed. She clearly did not want it passed, and the family and the doctor did, so they went ahead and passed it. Afterwards, I felt that I should have said that the patient had the right not to or at least identified that she had the decision in the situation. (R.D., interview 1.17)

...I guess when we restrain people. I guess when I first started I would probably restrain someone and then take them off. I would do it because I didn't know any better. I don't mean people would restrain people unnecessarily, because I don't. Most of the time they don't. At this point I may restrain them. But I also will give my input whether I think they need to be or not. And again, I don't think people restrain patients unnecessarily—except on the adolescent side they do occasionally. I have sometimes said I don't think we should restrain this person—I think we need to do this...(R.D., interview 2.15)

The person has the right to refuse treatment. I am not sure at what point people who are not competent, where that ends. I know I had a patient two weeks ago who came in for a medical matter and suddenly precipitated a psychotic behavior and he did not want to take his medications. He had very unrealistic ideas about what would happen if he would swallow this
pill... One day this nurse asked me to go in. See if I can get him to take his medication. He absolutely did not want to do this. It was not life threatening for him not to have it but it was hard to convince this fellow. I am not sure at what point a person has a right— he did not really have a good command of what was realistically happening to him thus far. This was a good excuse. He finally did take the medication. This is a hypnotic drug. Hopefully he would get some rest which he has not had. But it was not life threatening for him not to have it and it turns out that even with it I did not see any change. That made it a little bit worse for me. (E.A., interview 11.9)

Acceptance of Patient's Values

The ANA Code for Nurses with Interpretive Statements (1985) states, "consideration of individual value systems and lifestyle should be included in the planning of care for each client". These student nurses appeared to be more conscious of this component of respect when perceiving its absence. However, the following excerpts from data illustrate how two subjects evidenced acceptance of patients' values.

Possibly frightened, she seeks to control her environment completely. She refused to sign to allow administration of medications or treatment. Actually, she signed the paper but crossed out the statement saying she would accept meds. She will not allow traction to be applied, she refuses most meds, and insults almost everyone who enters her room. I found out that she writes poetry and asked her to recite some of her poetry for me. This she did from memory. As I said, she is very talented. She liked me, said I wasn't a bonehead like the others, but didn't cooperate with treatment anyhow. I thought I can cope with this as long as I see her behavior as a manifestation of her own fears and problems, and not a reflection of my deficiencies (E.A., log 2.2).

During a post-partum newborn assessment I noticed a red paste on the baby's umbilical cord. The
mother didn't know what it was — her grandmother had given it to her. She thought it was made from tree bark...I plan to find out more about the red paste...I can't agree or disagree with its use until I learn more about it (P.S., log 5.23).

Evidence of how nurses responded to patients and families whose values differed from their own is presented as follows:

I was particularly concerned about a lack of sensitivity in family relationships and functioning when the client and family differentiated significantly from the nurses' own family in the cultural dimension (L.B., log 15.14)

I work full-time and I have seen unfortunately many examples of how I would say things ought not to be done. Talking about patients in report, "Did you see his mother yesterday? She really looked a mess". These things are not relevant to this patient's care. Comments were made, "Oh, look how good looking his boyfriend is". Comments that do not belong in there (S.L., interview 1.12).

The staff described him as a liar...I became very angry with the staff because they say him as "evil" and described him as lying. He tended to spit on the floor, I gave him an emesis basin. However, people saw "intent" where there was none. He didn't spit at people. He just spat (F.W., log 3.2).

Some of them said, don't worry about her, she is just scum and that bothered my sensibilities quite a lot whereas her saying "fuck" really didn't offend me. So that really pointed up a value to me very clearly. Accepting the client as the client is and not making a value judgment. For a nurse to call a patient "scum" just outraged me. So that is one, just real respect and acceptance of the patient (L.B., interview 1.21).

In interpreting these findings with regard to respect for patients and formulas, one seeks an answer to the particular question, what are the ethical "rules" under
which these nursing students appear to function? To begin to answer that question calls for review of the first ethical injunction of the ANA Code For Nurses:

"The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

Based solely on what the subjects have said, one would be inclined to say that these nursing students were committed to this ethical principle. The data provide evidence that not only were subjects able to articulate what was "right" but were able to identify what was "wrong". While it has been said that ethics is not a matter of true or false, at least as far as ethical judgments are concerned, one must always keep in mind that as far as the nursing profession is concerned, there can be no argument. The ANA Code For Nurses is a set of principles prescribing the nurses' ethical duty to his or her patients to self, colleagues and the profession.

Respect for Self, Colleagues and the Profession

Kant's Humanity Formula (Kant, 1965) concerning respect for persons reads as follows:

Act in such a way that you always treat humanity whether in your own person or in the person of any other, never simply as a means, but always as ends.

Although these nursing students may not have had Kant in mind they were conscious of the need for self-respect, for and from colleagues as well as some sign of respect for the nursing profession itself.
Self-respect. Kant's view of self-respect is that persons have duties laid upon them by their own reason. In addition, persons need to be aware of their own dignity as moral beings. One subject seemed to be referring to indignities in the following excerpt:

A lot of pettiness goes on and I feel that the amount of respect you have for yourself you deserve that respect in return. You take the reactions people give you with a grain of salt. I have learned that because I am a very sensitive person but you learn to toughen yourself...I don't know what possesses people to act the way they do sometimes. Not only your peers, nurses, but also other professionals. But that will not influence me in treating persons differently. I will try to respect them as much as I can and treat them with respect. Collaboration is a big thing. It is communication with others, with the staff and with patients. That is one of the important things. I have seen instructors and other preceptors interact with people in a professional way and I want to reflect myself in that way. I want to learn to speak and act professionally...With some physicians I have had bad experiences. To me they feel they are better than me. They are more knowledgeable. They are not better than me. I treat them with respect and I have had one physician to whom I said, "Could you treat me with more respect?" (M.L., interview 1.4)

People make you feel like a jerk if you do something wrong. You may have the strength to admit that you made a mistake but just because everyone is going to make you feel like a jerk and an incompetent fool people don't want to admit it. And they avoid it or they want to hide it and they may not believe that that's the best way to do things or that's the right way, they may think there's another way to do things. They won't speak up because people make fun of them - you have to get along with people you work with - or you do it the way the institution does it even if you don't agree with it. (D.Q, interview 6).

I also believe there is such a thing as a nurse's right and not just dealing with a patient. I have been there a lot and I have seen a person abused. Nursing needs to realize their own rights. Their right to organize themselves,
their right to present themselves in a political way. Their right not to be abused whether it is by a physician or by a patient. I am here, this is what I am doing for you. You should have some respect for me. (S.L., interview 6.14)

Downie and Telfor (1970:87) discuss self-respect at length and their views are briefly summarized in the following quotation:

First of all, a man is accused of lack of self-respect if he is willing not to be his own master. A man who allows others to "push him around", who refuses to stand up for himself, who lets himself be dependent or dominated, is naturally regarded a despicable, to be looked down upon. He can also be looked upon as less than human, in the sense that a human being is characteristically self-determining; Sartre would say that a man who refuses to acknowledge his ability to be self-determining is behaving like a thing.

While nurses have often been depicted as being "pushed around" these emerging professionals appeared to be saying that they were not going to accept it. The following excerpts support subjects' awareness of nurses' rights.

My chances of practicing nursing the way I think it is probably "zip" just because I have decided to change into a different profession...The constraints would be the fact that I am a very outspoken person to sit back and be subservient to the setting they want you to be in...I was very disappointed when I got out into the work field and found out what nursing is all about. I am a very "people person" and I like working with people, that doesn't bother me but I don't like not being respected for the background that I have. (D.Q., interview 5.10)

Another thing, not relating to patients, but as far as nursing in general, I really think it is very important that nurses consider themselves as professionals and be treated as professional and stand up for themselves a lot. Partly by just conducting themselves in a professional manner. (L.B., interview 7.20)
Respect for and from Colleagues. The ANA Code for Nurses does not specifically address nurses' relationships with each other. It does make reference to "collaborating with members of the health professions." The International Council of Nurses (ICN) specifically addresses intra-professional relationships as follows:

The nurse sustains a cooperative relationship with co-workers in nursing and other fields.
(The International Council 1973)

The United Kingdom Central Council (UKCC) Code of Conduct (The International Council, 1973) addresses professional relationships under a general category called "Responsibility to Colleagues." The following quotations are considered of particular interest to this study:

In general, relationships with colleagues in nursing and in other health care professions should be determined according to what will maximize the benefit of those in their care. The goal of "whole person treatment" determines how nurses should relate professionally to their fellow nurses and to members of other health care professions.

Professional relationships between nurses and doctors should be regulated according to the particular expertise of each profession. *In the case of medical treatments nurses are under an obligation to carry out a doctor's instructions except where they have a good reason to believe that harm will be caused to the patient by so doing.

Intraprofessional respect was of considerable concern to these nursing students, many perceiving that nurses did not support each other. One subject said it this way:

I don't think nurses are half as kind to each other as they are to the patient. I think there is a little lacking there that I wish were untrue...but I see a lot of backbiting of one
another which is very distressing to me. (E.A., interview 7.1)

"Backbiting" was a term used frequently:

I feel nursing is very competitive and nurses back-bite each other and that just bugs the crap out of me. I hate to see that because I have been in a lot of institutions and nurses have really been out against each other. Certain ones that came from one institution and other ones from another institution and they are all talking about each other and even though you go through the inservice of conflict management and things like that it is not resolving anything. I don't know maybe because it is a female dominated professions. (D.Q., interview 1.15)

In terms of backbiting...on the floor and also myself...I think a lot of us go into nursing...because we really want to be liked. So we want to have patients like us, there is a jealousy of who is real popular. Most of it is not directed toward the male nurses. Everyone likes the male nurses. I think the male nurses have less personality problems on the floor. But we have a high male ratio which is fairly uncharacteristic...and maybe that's why the floor is a happier floor...They don't have the insatiable need to be liked. (F.W., interview 10.10)

I saw a lot of nurses talking behind their back, back-biting kind of comments and gossiping (F.V., interview 1.4)

Respect for colleagues was associated with not participating in "backbiting" or "backstabbing."

I worked with one nurse in particular that had been an LPN and I really had a lot of respect for her, she had a different kind of nursing. She took a lot of time with her patients...She wouldn't talk about other people. She never said anything bad about other people. If there is someone she really needs to stand up for, like the LPN, she really presented a good argument - one night we were having a discussion on that and I respect her for that...I wouldn't say she was anything like the professional image the College of Nursing puts forth but she had qualities that I thought that I saw in professionals. The other staff would get into back-stabbing and back-biting and I really disliked that about working at that hospital. (K.P., interview 1.19)
Respect for the Profession. The ANA Code For Nurses devotes four of eleven principles to the relationship between nurse and the profession. These are as follows:

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

If one briefly reviews the Interpretative Statements (1985) one becomes aware that the professional nurse is expected to assure the public of quality nursing care. This responsibility carries with it the charge of monitoring the standards of nursing practice to assure a measure of safety and to participate in efforts to upgrade nursing standards. The Code For Nurses urges nurses to be concerned with conditions of employment, especially when quality nursing care is threatened.

The nursing students in this study evidenced that they were concerned with standards of nursing practice. They
appeared to link quality care to continuing education and a commitment to nursing as a career and not "just a job."
Continuing education is the theme of the following piece of data:

Keeping up with your profession is a very valuable thing to keep in mind because even though it changes so quickly you know if you don't keep up through organizations or contact with your fellow workers, RN's, inservices and things like that I think that also makes you a professional. Your behavior, your dress, again how you make contact with that person, make them feel comfortable, feel they can be open and share things. That means a lot. (J.E., interview 1.6)

I've learned that I will always be learning, whether it will be on-the-job, or reading on my own, or someday returning to school. I'm committed to being a lifetime learner. I may someday specialize in a particular area of nursing, but for right now there are so many different areas that I want to increase my knowledge and competence in; OB, peds, emergency nursing, etc. I want to feel comfortable in many different areas; to be a generalist (P.S., log 7.15)

Keeping standards high was viewed as a professional obligation and subjects were aware of the constant need for alertness in this area.

I realize I need to keep very high personal standards for my nursing career outside of the school setting and in some work areas more than others I can see that it would be possible to let standards fall, but I believe that I need to keep the same high standards no matter what setting I'm in. I believe that if I just remember that the patient is #1, that they are the reason nursing exists, then everything should fall into place. (P.S., log 7.10)

Carelessness and sloppiness were recurring themes which subjects perceived was a general decline in standards on the part of some nurses.
Some nurses are sloppy. Organization skills - like they won't chart medications. They haven't charted during the shift and they chart at the end of the shift (L.U., interview 2.10)

One thing is doing care plans. Some people were lazy and wouldn't do them... In terms of being lazy I have seen people who would not give baths. (A.M., interview 2.5)

Some of the nurses... I have seen some sloppy people there. I don't know why they are there. They are sloppy with their work and in dealing with the patients they can be abusive with their language. Sometimes they are very short with people (K.F., interview 4.10)

There appeared to be a particular sensitivity to what subjects referred to as "passing the buck." This concept appeared to be related to subjected perception that some nurses did not assume their professional role and evidence their knowledge.

Some of the negative - nurses that don't give themselves credit for what they know. They are always passing the buck, "well, ask your doctor about that". They are not willing to commit themselves or be accountable. (P.S., interview 2.14)

Not all, but a lot of nurses are just there for the job. They want their money... "I'll just do the minimal and go home. (A.M., interview 4.25)

This was a source of what one could only call embarrassment to these students. That nurses would evidence such lack of respect for themselves, as professional nurses, was one thing but that their actions undermined the public's view of the whole profession was something else.

When I look at nurses who don't assume the responsibility and try to shirk their duty and try to pass it off on to somebody else when there is a potential for them to answer. Instead of taking time, because they are too busy or because
they want to get out of there, to get done with
the day, instead of taking that little extra time
to seek the answer to the problem, they try to
pass it on to someone else and more often than
not, it seems that when that happens they (the
patient) never get the answer or are left kind of
hanging in the balance trying to figure out what
is going on...I think that overwhelming urge to
get out on time - I am doing my eight hours and I
am leaving - that kind of turns me off. (H.G.,
interview 2.15)

I have seen a nurse forget a prescribed dosage of
medicine at a certain time. She marked it in the
book that it was given and she threw the
medication away (M.L., interview 1.21)

Pride in the profession was evidenced over and over in
how these subjects described themselves as nurses and how
they viewed nursing. Yet, they always appeared to be
saying that the image of nursing which they held was not
shared by some nurses, by the public at large, or even by
other health care professionals. The following data bits
provide a description of these views:

I feel good about the nursing profession. I
wouldn't be in it if I didn't. I think that
different people have differing opinions about
what nursing is. Some people do not believe it
is a profession. I believe that it is. Some
people have a different perspective on what we
do. People that have been in hospitals...they
respect the work that we do. (J.H., interview
14.22)

I am a very people-oriented person...but I don't
like not being respected for the background that
I have... I am not pleased with the way nursing
appears...We know more than just wiping people's
rear ends...We have the knowledge and we are
striving for a profession but it is not happening
very rapidly (D.Q., interview 3.18)

Most of the physicians I have come in contact
with are very nice. But there are some who look
down on nursing. (S.R., interview 4.15)

The more I learned about how nurses are treated
and salaries the whole doctor-nurse game the more
angry I got. I still wanted to be in it. It was not enough to get me out because I knew it was what I wanted. (L.U., interview 3.4)

I knew when I was going into this profession that it was a service profession. You are giving a service. You get burned out. You don't get enough respect or monetary compensation. You are giving - giving all day long (P.S., interview 4.12)

I think nursing is being pulled to do more, to know more, to have a better knowledge base but still there is that old stereotype - the woman in white who is subservient. What we are required to know does not fall under that stereotype. I feel most of the time in clinical that I am as capable as any medical student there, maybe even more so. (N.O., interview 1.5)

Medical rounds were pretty cut and dry. Each child's lab values and problems from the previous day were covered, and some informal ideas were thrown out about what direction to go from there. One aspect that seemed incongruent to me was the seemingly little input nursing had into the process. Ideas were discussed among the residents but the nurse who was there, any other nursing staff had to jump in when they had something to add. There was not a whole lot that seemed to be needed that day, but no attempt was made to ask nursing for their input. (H.G, log 3.20)

The above pieces of data provide an interesting view of how these nursing students feel about their profession. They evidenced pride in themselves as nurses, pride in the profession and a fierce determination to hold on to the values they had. They evidenced lack of desire to tolerate conditions under which they perceived that the profession was being undermined by nurses who did not subscribe to the professional values. They voiced a desire that nurses and nursing be respected by themselves, by their colleagues and by the public in general. They seemed to be saying that nurses had the power to take
action through collective unity and a commitment to professional values. It seems redundant to say that they evidenced caring which they identified as the other ethic of nursing.

Caring - It's the Little Things"

Caring was closely aligned with respect in the minds of these subjects. In fact, it was intertwined. Subjects do not describe their experiences in terms of conceptual themes. It becomes the task of the investigator to separate and classify. In this case the investigator saw sufficient differences in the expression of these two concepts to separate them. The concepts of respect and caring were differentiated on the basis of conceptual quality. Caring was associated with showing "concern and love", providing psychological support, getting involved, being cheerful and friendly and "taking the time" to do a good job. The concept of caring for these nursing students can be best understood as being all "the little things."

It's the little things that are important to the patient - This man I had - he couldn't walk - he had been bedridden for a month - he couldn't even stand up and use his urinal. And he needed help to walk and the nurses didn't have time to do it. Yet, there are nurses at the nurses' station just sitting there yakking...Nurses need to have time to take care of patients. (A.P. interview, 15.25)

I think I am very caring and I try even if things are critical I try to keep things light and I have been taking care of a quadriplegic quite a lot but it seems like we can easily laugh a lot together even though there are a lot of problems that are going on. I don't know what I did but I had one patient I took care of at the hospital last year - R.C. I was there when she initially came in three weeks ago and went into skeletal...
traction. And she told me the other night I was her favorite nurse. I had not taken care of her except for that night three weeks ago so I don’t know if it was just coming in and talking to her while I was in the hospital taking care of other people. Just that kind of thing must have impressed her that she would actually say that to me. (A.C. interview 2.13)

There has been one particular nurse - she is a faculty member, but I have also seen her practice nursing with patients - this was a nurse that sang to her patient when I went to dry dress him. She stood there and she knew I was nervous and the patient obviously knew I was a student, he saw my name tag and had some ideas that I was new at this. This particular nurse sung to the patient; not only was this therapeutic for the patient, it was very therapeutic for myself - she gets to know the patients to a level that they are asking, "When are you coming back?"...it is passed on the other staff from the patients saying kind things about her and the wonderful things that she did. They were creative and she told me once, "it is not just my job -nursing is my career-. (S.L., interview 2.15)

She has been a nurse for five years. She was a nursing assistant two years before that and you could see the pride she takes in her work. I work on a Trach unit and what she does it, you know, when she was first showing how to do certain things, you know, you might be the evening shift coming on and she would show me how to do trach care, checking the children's necks where the rubber goes into the neck, she noticed the nurses before leaving cotton sticking around there or they were dirty or just wasn't done right...She believes some nurses are burned out. She is willing to stay. If it takes a half hour longer, she takes a half hour longer to get the job done right (J.K., interview 2.24)

My philosophy of nursing is based upon caring. I think that the profession should show concern and love to other people. I feel that when the caring aspect is left out, nursing interventions become ritualistic and are perceived as tasks that must be completed at a certain time. I think a good nurse is one who treats each of her patients as if they were a close family member. She is aware of their psychosocial and spiritual needs, and helps them to get these needs met. I see the nurse as a friend to the patient who makes the hospital seem less stressful and frightening. (S.N, log 5.9)
The preceptor I just worked with - she was great - she was a graduate from here - I am the type person - I like to do everything well - I am a real perfectionist and she was really thorough and she taught me things like I never used to think about likes a good back rub - powdering bathing - she could do it well. (K.P., interview 1.2)

The exceptional nurses did those things, holding hands, talking to them, telling them what was going on. Being real open and honest with the families. Giving them psychological kind of support along with the physical. (F.V., interview 1.11)

Caring was viewed by these nursing students to be of such importance they had internalized it as part of their self-concept. The following excerpts from data are only examples of the responses received in answer to the question "Tell me what kind of nurse do you perceive yourself to be?"

I think I am a caring nurse, a nurse who is kind of an affiliator. I care about establishing a good rapport with the patients and making them feel comfortable in the situation where they may be a little confused. (L.B., interview 2.22)

I like to think I am empathetic. In fact sometimes I find myself being sympathetic and I think no, I shouldn't be sympathetic, I should try to view this patient as if I were in his situation. What he would want if I were there. I like to think I am friendly and patient. I am a safe nurse. I have always kept that uppermost in my mind. (J.F., interview 2.18)

I am a very caring person. I have had staff members tell me if you keep getting that involved you won't last here. On the other hand I have had patients saying well I feel that you care about me you are not doing this because it is your job. (J.K. interview, 5.15)

I think I am a good listener, a good communicator, somebody who understands what the situations are and can adapt to those situations.
Someone who is flexible and not real rigid.
Somebody who can shift if the need be. (H.G., interview 4.1)

I feel pretty confident that I am a good nurse. I take the time and explain things to my patients. I go back and say, "Is there anything else you need?" Maybe they have another problem like a sick child at home and can't get home, they are stuck in the hospital. (L.T., interview 2.5)

I am caring. Not only caring in personality but also using the skills I know to meet patients' needs. (S.N., interview 3.8)

I think one thing they would say is that I am happy and that sounds kind of corny but when you are in the room and you are talking to these people they always say how come you are always so up - how can you be cheerful - it is three in the morning. It just makes the difference to the patient when you walk in and say good morning - you might just be checking his IV but you are starting his day. I think probably from a peer's perspective I enjoy being organized and part of that is just learning to prioritize things - I did that real well throughout school (S.L., interview, 3.15)

A brief review of the dimensions of this concept reveal that these nursing students describe it in terms of:

- Meeting patients' needs
- Showing love and concern
- Going voluntarily to talk to patients
- Being cheerful and friendly
- Taking time to do "the little things"
- Being empathetic and a good listener
- Getting involved
- Being open and honest
- Being a safe competent nurse

The following data reinforce these categories as the subjects describe nurses doing "good" nursing.

...nurses I have worked with and as a student I think they do care about the patients and the families. They usually take the time to do the job and make sure they are doing it right. I think that the biggest thing I can say about
working on a cancer floor you see a lot of that. You have the families with the new diagnosis. You have got to be there for them. You have to help them through that stage, answering any questions they might have or just be there through the tears. I have also seen it when the child has just died. They are there for the family, they attend the funeral to show that they did care and also to show their own grief... (J.K., interview 5.21)

A lot of nurses would be real routine but this one nurse I worked with, she was real thorough with her care more than others. She would check the catheter every two hours and other nurses would just sort of glance at it. (P.S. interview, 1.15)

Last week I spent one of my clinical days with a clinical specialist for our unit and she was wonderful. I saw a different side of nursing but also basic care. She was coordinating the transfers from her own unit to rehab unit and really coordinates a lot of discipline and talks to a lot of people but if she walks into the room and the patient is in the middle of the bath and the patient says he is finished with his bath but couldn't reach his back, she washes his back and still does little things like that. She does a lot of different nursing things and not just the basic nursing or hands-on stuff. (A.C. interview, 1.10)

The importance of the concept of caring for these nursing students cannot be overstated. It would appear that they not only perceived caring as an essential ingredient to "good" nursing, but that for a nurse it is the "right" thing to do. Gilligan (1978) has said that women's moral development centers around an ethic of care and a responsibility for not hurting others. The ethic of care becomes a universal obligation. Noddings (1984) in her feminist approach to ethics describes the ethic of caring as "I must." She is, in many ways, advocating an ethic of virtue. Kant (1965) also has classified duties
of virtue, under the headings of: (1) duties to ourselves and (2) duties to others. These are further classified under (a) perfect duties to ourselves, (b) imperfect duties to ourselves, (c) perfect duties to others, and (d) imperfect duties to others. Nell (1975) in discussing Kant's theories says that for the most part ethical duties are all classified as imperfect duties since "it is impossible to compel, cajole or manipulate others into doing their ethical duty" (Nell, 1975:45). The point is that duties of virtue and duties of justice form two mutually exclusive lists. Caring, therefore, would be considered a duty of virtue because one cannot compel a person to care. Another dimension of caring was provided by these subjects. That is, caring is painful.

Caring is Painful. The dictionary defines caring as a state of mental suffering, to care is to be burdened, to be involved with someone. Noddings (1984) talks of caring as "engrossment." It would appear that caring is not easy. When one cares, one experiences pain as indicated in these data bits:

I have really seen quite a lot of patients die lately. Part of me is sorry and part glad to see that suffering is ended. Sometimes I want to cry when I take care of a patient, especially if they remind me of someone. (L.T., log 10)

I felt helpless, in the way and a little confused at my feelings. I think I was too turned in on myself because I felt as a professional I should not be having these emotions. I should be able to control them because by co-workers will not understand. I sorted out my feelings and decided that these are normal emotions, especially for a new grad and I'm just a sensitive person which I think is a good quality for a nurse to have. (V.J., log 4.9)
I was terribly sad when I went into a room with one family whose 50 year old daughter was the patient. She had lung cancer which had metastasized. They brought along a long page of questions which the doctor faithfully answered - the hardest one being the life expectancy which turned out to be only about six months with no treatment. I went out to try to comfort them. I felt so helpless. I ended up just simply staying with her for a while because she didn't want to talk. (L.T., log 4.14)

The family with the 5 month old infant is a close one, too. This is a young family of 2 parents, a 4 year old boy, and a 5 year old boy. This family isn't able to come in very often because of their other 2 young children and their jobs. I was able to talk to the mother when she called to ask about her son. I provided a listening ear as the mother expressed concerns, fears, and feelings of sadness of not being able to be with her baby like she wants to. I would like to work more with this family. (J.K., log 2.12)

On Tuesday night I cared for K.B. and his family and friends. We were doing nothing for K.B. but IV's and epinephrine and morphine and tofrinol. His parents, grandparents, girlfriend and many friends were with him throughout the night. I was so glad that he was back in the isolation room all by himself - it made it possible for his death to be the way his family and he wanted it - with all the closest loved ones at his side. He survived for so many hours with unbelievably low B.P. - in 30's. Both his parents and girlfriend had told him it was OK for him to go. He finally died at 5:30 a.m. Then D and I did the postmortem care. I'm so glad I could have this experience - it was a good, loving death with dignity. But it was also hard to see a patient die that I knew as such a great kid with so much going for him and so much to live for. I guess in nursing I'll relive this scene many more times. And I also think that I can be a nurse who's comforting and comfortable with this. It was a tough but a good experience. (F.V., log 5.10)

L.A. died on the floor this week. A child also died in the ICU and three at home. I guess being a new grad and never had been exposed to this before I had certain expectations of staff reaction. I think that much of the coping took place off the floor in their own way. In a way, as a result of that, I worked through it myself.
too. I talked to friends and thought about it for awhile. I know those kinds are better off and so are their families in a matter of speaking. (J.H., log 5.23)

These data bits reflect underlying pain and something else - a confusion as to the appropriateness or acceptability of these feelings. Am I supposed to feel this way? There also is an inference that nurses handle these feelings "in their own way." The following excerpt from a log provides additional data with regard to this:

In the case of the young man dying on the unit now, the frustration and anger is very evident in their voices and the way they talk. As I said this is new to me. It is all very hard to sort through at times. The pain, the grief of the staff and the parents. The frustrations and helplessness felt when a kid is dying and you can't do anything. (H.G., log 10)

Pain, grief, helplessness, frustrations, are all part of the induction of new members to the nursing profession. Another subject describes an added dimension - fear:

Mistakes happen - it could be you or me that makes the next mistake. How do you deal with that fear? A nurse on our unit made a mistake this week - she was supposed to hang a new insulin bottle, instead she hung a bottle of epi. Had the mistake been reversed - had she hung an insulin bottle for an epi bottle it could very likely have killed the patient. These things are difficult for me to deal with because I know how easily it could happen to me. (F.V., log 6.18)

Clearly, for these nursing students "reality shock" is traumatic. The following excerpt from a subject's log provides more insight:

I took care of five patients today, and I found myself frantic most of the day. Just when I was "pre-oping" my one patient for his cystoscopy, I received my other patient from day surgery. This
all occurred about 10:00 in the morning, and I was behind in providing care for my patient with cancer who needed a complete bath. Charting was definitely not one of my priorities at the time. I charted what morning assessments I could, and then I got caught up again at the end of the shift. (S.N., log 6.9)

This was a fairly typical example of subjects' anxiety and general unpreparedness for assuming a heavy patient load. However, what appeared to be an even greater source of stress seemed to center around their fears of compromising their own standards. One student described it this way:

I think there is pressure to conform to existing standards. I think there is room to grow and to change things but you have to be a very strong nurse to do it...Get it done - that is the hospital policy. Cutting corners, get it done quickly - not necessarily the best way. Time is the one constraint for me - peer pressure would not bother me as much as time. (L.T. interview 3.13)

"Cutting corners" was perceived by the students as "not taking time," not "giving time" to the patients. They described nurses who acted this way as uncaring. In fact, uncaring professionals was apparently viewed as a major cause of disillusionment. One subject described the following incident:

I had a back-up nurse who came up to me and she came up to me at the end of the shift and said, "could you flush a 'hep' well?"...I went back to do it and the patient didn't have a hep well and I thought, that's weird...He told me he had his hep well discontinued at 8:00 that morning. That made me wonder had she seen this patient all day? Has she given any time to him? Did she give him his medications, did he get the care that he needs? I went back to her and said, "Did you know he had his hep well discontinued early this morning?" She said, "Oh, did he?" and she just kind of laughed, like it was a big joke. (J.K, interview 2.5)
This subject evidenced shock that a nurse would act this way. Yet, it appeared that subjects received many similar shocks.

Also, I think physicians that go into rooms, they don't read instructions, they don't necessarily glove, they don't wash their hands in some instances, and then they go off to another patient and I really can't see how these people can have either a patient or any patient's best interest at heart. (J.E., interview 5.2)

For instance, the nurse who charts that the patient's chest tubes are draining fine, the patient's peachy keen. And you go in the next morning and the patient is in very serious condition and in reality the nurse had a very high patient load and never looked in on the patient because the chest tubes had been pulled the day before. (J.H., interview 1.21)

One thing that bugs me is when nurses do dressings and they don't keep sterility. They are not even clean...I like cleanliness in the room itself...You have to pick up after other people and clean off the patient's bed table just so they will have some room to put their water pitcher or something else on it. (K.F., interview 1.12)

In the operating room there are so many times where a nurse gets so caught up with the technical side of surgical nursing that they forget about the patient and the patient is left on the OR bed looking at all those scary lights and everyone is functioning and he is forgotten about. A lot of times mistakes are made that way. A case in point, I had a patient that was coming for an amputation, and we were rushing around the room and we had two residents and a medical student coming in and the medical student was prepping, this was a 95 year old patient and he was not oriented, his daughter had okayed the procedure and the medical student came in and prepped the wrong leg. I had to stop him and granted this man probably wouldn't have known the difference and he had poor vascularity in both legs and he would have lost that leg eventually, but the fact was that the wrong leg got prepped. N.O., interview 4.2)
Apparently, many nurses become accustomed to much pain and to many circumstances over which they have no control. One subject said:

I think we as a profession have become callous to some of the things that we have to do to patients. Some of the things we have to deal with without a lot of support and you can't meet all those idealistic needs. (N.O., interview 4.19)

Callousness as a concept was described in the following way:

I just thought of an example of the callousness of this one nurse. Not caring is a better word than callousness. She was an ICU nurse working on a 12 hour shift. I was there as a student. She came in, she was very abrupt. Up went the shade in the morning in this ICU open room. This little old lady who weighed 96 pounds turned her head toward me and she said, "Honey, I can't stand that light." She said, "I have a brain tumor," and the nurse said, "Well, I like light and I am here 12 hours a day. I come in when it's dark and I leave when it's dark and we will have light in this room." I never had the pleasure of working with this nurse again and I have always felt extremely guilty because I didn't step in and say...Well, later on in the day we did close the shade a bit. In time, the lady just turned on her side and faced the other direction. (J.E., interview 7.21)

In describing these incidents subjects are not only reliving what apparently was a very painful and disillusioning experience for them, but in some ways, perhaps they have also internalized a feeling of guilt.

Another subject provides an example of a case in which an elderly man, very ill, was having surgery. She recounts how the OR "scrub tech" was asking why the man was having surgery to which the surgeon responded that it was palliative. She then goes on as follows:
Finally, after numerous biopsies the resident looked up and said, "Yeah! We could do the surgery but it will probably kill him." After that statement the surgeon conceded and we closed. (N.O., log 4.8)

D. and her family decided if she were to arrest there would be no intubation and no chest compressions. They made a new goal, to get D. back in enough shape to go back to the floor and from there to return home. D. and her parents do not want her to die in the hospital. I saw some very interesting things happening with D.'s care as far as the nurses go. D. was a "difficult" patient to care for. She was so demanding and withdrawn and her care was very complicated. D. was not picked up by any of the nurses as a primary, and many of the nurses complained about having to take care of her. In my opinion she got technically competent but emotionally deficient care. I can see why the nurses acted the way they did. D. was not a rewarding patient to care for and no matter what you do she is going to die anyway. I can see why D. acted the way she did (Who wouldn't be angry, sad, and afraid in her shoes? Probably just now beginning to believe she is really going to die, being so far from home, being in the ICU and all the implications going along with that, leaving the floor nurses who have been so supportive). When I am faced with a demanding patient I want to remember this experience and try my best to give both emotional and physical care. (F.V., log 3.15)

Caring Requires Courage In the previous data bits one underlying theme is guilt. These nursing students appear to be struggling for some inner resolution, struggling for self-acceptance, yet aware of their relative powerlessness in the situations. Another subject who evidenced much torment over this problem said it this way:

One issue that I am clear about is what I think is the ethical thing to do. I have had some trouble doing that because of the need that I feel to fit in with other nurses. Not to offend other nurses, not to sabotage the working relationship with the colleagues I have to work with. (L.B. interview, 6.12)
Another subject who had also thought deeply about this problem, said:

I have not been tested in certain ways. I don't know, it is easy to just sit and say that I would stand up for the patient against the powers that be. I would be the patient's advocate. I don't know if I needed a job and I am in an institution and I know that bucking that institution is going to lead me straight out the front door and maybe even without a job. I don't know how much strength of character I have to do that. (E.A., 10.21)

Yet, these nursing students did expect nurses to be advocates. They expected it of themselves and they expected it of the nurses they had worked with. They evidenced disappointment in those situations in which they perceived that nurses had not spoken up on the patient's behalf.

Something I saw in role transition was this little boy and he was supposedly a suicidal case... (His parents) were saying he did this, he did that and all these terrible things but they (the staff) never looked into it and they went ahead and did what the parents wanted and sent him to an institution. I thought that was horrible because I had taken care of him for about a week and he was just a typical little kid. The doctors made me mad with that. The nurses didn't really say anything. I said something to the nurses but they said, "It is the doctor's decision. there is nothing we can do." (S.R., interview 1.24)

We nurses say amongst ourselves, "what are we doing for the patient?" But no one says to the physician, what are were doing for this patient? No one stands up for the patient. There are some who do...They talk to the family and the physician. (K.P., interview 2.21)

I also felt that nurses' relationships with doctors and anesthetists were not always as collaborative as they might have been, with nurses sometimes questioning physicians' decisions among themselves but never discussing their concerns with the doctors or anesthetists. (L.B., log 25.15)
Nurses were saying, what should we do? Someone has to tell the family. And the nurses were saying, someone should be with him when he is told, but the doctor came in and told him and there was no nurse there at the time...I think nurses don't want to make waves. They don't think they have the authority or the knowledge base. They don't feel like they are going to be heard. (K.P., interview 2.24)

In briefly summarizing the answer to research question number two, the findings revealed that subjects perceived the ethic of respect and the ethic of caring as the most basic nursing values. Respect was described as having respect for patient and families, self colleagues and the profession. Respect for patients and families was described as having three dimensions: 1) Respect for the human dignity and uniqueness of patients and families, 2) Respect for patient autonomy or self-determination and (3) Acceptance of patients' values. Respect for self, colleagues and the profession was described in terms of self respect as a professional and being and acting like a professional and being and acting like professional in communication and collaboration. Caring was perceived to be multi-dimensional. It was described not only as subjects perceived it, but through their voices in experiencing it. Caring was found to be painful and subjects' experiences evidenced that caring also requires moral fortitude.

Research Question 3 Research question number three was concerned with the influential forces which the subjects perceived as having the greatest impact on their present view of themselves as emerging professionals. The
subjects’ responses are briefly summarized in Table 3 which will be found in Appendix G. The most frequently cited influence was “the school” and nursing instructors. Several subjects identified family and friends, also. The concepts of respect and caring come through in these excerpts from the data. First, some subjects cited the influence of the college:

I think school had the impact. The program is not easy. It is demanding. It is challenging. You have to really want it to stay in it. I know half way through it when I started having problems I kept saying to myself, is this what you really want? Because I wanted to be a nurse since I was 12. I take all that I have learned, and I am working every day, not just one day a week and I feel that I am part of the team. I feel that I am responsible and I know where I am going, what I am doing and I look back now and I thought all that hard work was worth it. You finally found your niche and what you wanted (J.K., interview 3.1).

My education has changed my viewpoint a lot as a nurse. It has been the biggest factor as far as understanding that there is theory and research and nursing is a profession and it’s not just that stereotype, a lady in a white outfit, that I thought nursing was (N.O, 3.15).

This school should really be commended for they have really pushed the idea of professionalism and the identity as a nurse. Especially the last year or two, going beyond to strive, to make more of nursing. When I first went into nursing I thought of it more as a doctor’s assistant. (N.O., interview 2.18).

Most subjects identified the influence of instructors. The following excerpts illustrate their views:

The faculty here have really changed me. I am more assertive now. When I first came here I was really shy. I wouldn’t talk to anybody and they really pushed me to become assertive. I really never thought they were picking on me. I kind of felt negative at first but I could see what they were trying to do and now I am really glad about
that. Starting in a clinical area without your instructor you don't know everybody, and everybody is not going up to you and say, "Do you understand, do you need help? (V.J., interview 2.1).

I think that is the one thing positive that I have gotten from my instructors that I take the time to do it correctly. That has reflected in all my nursing work. Not rushing around, there are some things you have to get done in a hurry where granted you don't have the time you need to do them. But I would say doing it right the first time even if you are taking a fraction of a second longer to be sure you have done it right. What I have learned from my peers that influenced me is they have all been positive, also. It is just to be myself. They have respected that (K.F., interview 2.24).

The people here at the college have been more of an influence to me than I would like to admit. I had a very good medical-surgical professor who believed in me...but she really believes in her students and she also teaches you how to correct your mistakes which is something I found in school. Nobody makes mistakes!! Maybe nobody talks about their mistakes. People make mistakes all the time and what is part of learning is how not to be part of the problem...She was real cool about mistakes and she taught you how to make out an incident report and wasn't punitive. She was a good influence on me. She also has a good sense of humor (F.W., interview 5).

Several subjects identified the importance of family and friends. The following piece of data not only supports this but also articulates well the relationship between the self-concept and those influencing forces:

If I were to look at one of my main forces, at least from the realistic end I think I would look at my family, my parents in particular. I think I get the caring part of me, the willingness to go the extra mile, the willingness to sit down and listen, from them, because they have always done that for me and they have done that with multitudes of people and I have seen them do that. Education wise, all through grade school, all through high school, teachers have done the same thing. I kind of think the caring side of me and that willingness to do what it takes is a
reflection of what I have from my roots so to speak from my parents on up through education. Being here, the caring was mixed into the ideas of being responsible, being honest, being accountable. Not just being professional but of taking your own personal characteristics and molding them into the image you feel you should have (H.G., interview 2.15)

The meaning of these findings seem clear. Subjects evidently felt strongly that their self-concepts as nurses were highly influenced by the curriculum and the instructors. Some even indicated that they had grown personally as well as professionally. Another important dimension of the influential forces perceived by these students was the notion of discipline. Subjects apparently perceived that they had had to work hard and appeared to be experiencing a sense of pride in their own achievement for which they appeared to credit "the school".

Research Question 4 Research question number four seeks to know who these subjects perceive their future and in particular what they perceive to be their freedom, or lack of it, to practice nursing according to their own standards. The summarized responses to this question can be found on Table 4 in the Appendix G. One can see that subjects on the whole identified "control" as the major factor. They appeared to be saying that the only thing they could control was the choice of where they worked, after that they indicated it was a matter of making the best of the situation. In fact, of the twenty-three subjects who answered the question only seven were quite
optimistic in their responses. The following excerpts support these views:

I think my chances are good. I am not the only one who feels this way. I guess maybe I came to this doom and blue picture of nursing but something that is important is that nurses identify it. They know it is going on. The majority does, more than people think. Professional organizations are getting bigger. There is a lot of hope for nurses to say, "wait, we want more status so that we can do our work" (S.L., interview 4.10).

I think the future is pretty bright. I think it has a lot to do with the area of the country and the institution that you choose to practice in. The institution that I will be working in after graduation, I know the main reasons that I chose to work there were there are many opportunities, not only in learning but for advancement (J.A., interview 7.18).

I see the future as nurses having more responsibility - more freedom to do what they - in the care they give - one because of the shortage of staff and two because nurses have grown so much - since the day of Nightingale to now - just the responsibility they have - the competence. I see a lot of them walk around with the knowledge they have - I just think you know there is a lot more education - a lot of them are going not only for bachelor's but for master's and doctorates too (J.K., interview 3.24).

Most were cautious in their view of the future. The following pieces of data support their view:

I will try my best to be able to do everything the way I see it should be done but I know it is unrealistic to say this is the way it will be all the time. I know where I am going to work they do an RN-LPN kind of partner where they give them 9 patients and they divide them up between the two...You can't always do everything you want to do but I think if you really try and you prioritize and you use your time well you can pretty well do what you want to do (S.R., 3.8).

At the particular institution that I was in I feel I could do a pretty good job of practicing nursing the way I was taught except for the time. I have been rushed. I feel as though I could do
a pretty good job. Except I see myself getting in a rut...it is an awful lot to expect. Get it done. That is the hospital policy. Cutting corners, get it done quickly, not necessarily the best way. Time is the one constraint for me - that is the hardest. Everyone has one thing that bothers them - peer pressure would not bother me as much as time (L.T., interview 3.10).

On the other hand, others were quite pessimistic about their freedom as ethical practitioners:

I have decided that I could not be a staff nurse for long and the major reason I feel like that is I don't think I have the power. I do not have enough opportunity to make decisions about how I think a patient should be treated...I think that would be real frustrating for me. In a lot of situations even though I would be working for the hospital with all its restraints with all their policies, in a lot of ways you have to treat patients and do patients the way the physician says. I see those as being constraints. (A.M., interview 3.15)

There is a lot of pettiness in nursing and there is a lot of garbage work that has to be done, and the only person that can see that it is done is the nurse...there is a real shortage now, and I will probably be overworked...It will be interesting...I don't think the future of nursing is very bright...I think we have to rely on relatives to take care of their families because we don't have the number... (F.W., interview 9.20)

I see nursing eventually done away with...I don't know what will happen. I don't now - a big rift of some kind in the future for nursing. I haven't been in the field that long but all I know is there's a lot of nurses dissatisfied with nursing. A lot of them want to get out. It shocked me in a way. (K.P., interview 5.15)

My chances of practicing nursing the way I think it is is probably "zip" just because I have decided to change into a different profession...the constraints would be the fact that I'm a very outspoken person to sit back and be subservient to the setting they want you to be in...I was very disappointed when I got out into the work field and found out what nursing is all about. I am a very people person and I like working with people, that doesn't bother me but I
don't like not being respected for the background that I have. (D.Q., interview 5.10)

In examination of these responses, one can see that locus of control was a very important theme. Those subjects who were optimistic perceived that they were in control. Those who were cautious were uncertain about it. And those who were pessimistic were sure they would not have authority and control.

It appears clear that these nursing students are not naive about the reality of practice. What is not clear, however, is how much cognitive dissonance is taking place. There are a few indicators that subjects have begun to make certain compromises for example the subject who said the she/he believe in "going with the flow" and the subject who talked about time as a problem. It is also quite appropriate that a few subjects have already decided that hospital nursing is not for them.

Research Question 5 Research question number five is focused on the subject's judgment of the ethical standards of nursing colleagues. The responses to this question are presented in Table 5 in the appendices. The answers to research question number five were received in response to the following question, "How do you perceive that nurses in general accede to an ethical code?" You are to judge them against your own standards. Responses revealed that many of the subjects perceived nurses in general as uncaring. The implications of this is startling. Are these subjects out of step with the rest of their
profession? It is important to reveal here that this was a very difficult question for students to answer. Most evidenced discomfort. Some subjects hesitated before answering. One can believe that for these students, it was a little like talking about ones family in a public forum. It was difficult for subjects to say what they said. The deciding factor appeared to be in evaluating most nurses against their own standard which had emphasized caring so much. These responses are examples of such ambivalence:

I think nurses in general are very caring people...It might depend on the point in a nurse's career and whether they still like it (J.H., interview 4.15)

I would give them a 6 or so on a scale of 1 10...a lot of nurses, not all nurses, but a lot, are there for the job. They want to get their pay and go home (A.M. interview 4.21)

There is the good and the bad. There are many nurses that are burned out and they are just there. Then, there are others...they just shine...because they like the work (V.J., interview 3.15)

Nurses in the work setting-I would give them a 5 or 6. There are a lot of good people out there...but there are a lot of that - just view it as a job (D.Q., interview 4.18)

I think they meet the standard for competency well, maybe an 8 or 9, but the caring I don't see. Caring I would give a 5 (F.V., interview 4.18)

Some didn't hesitate. The following responses represent those who appeared to have their minds made up.

On the average, I would say fair...I think broadly speaking I see nurses not seeming to care about their patients or not being able to demonstrate that they do (L.B., interview 5.18)
On a scale of 1-10 I would say 8 1/2 - 9 most of the nurses I've known... take the time to do the job and make sure they are doing it right (J.K., interview 3.8).

Most of the nurses I've seen would rate a 7 on a scale of 1-10 (P.S., interview 8.16)

Most of the nurses I've come in contact with have lived up to my standard (F.W., interview 7.15)

Research Question 6 Research question number six focuses on how these subjects perceive that they are implementing an ethical code in their everyday practice. Table 6 in the Appendix G provides the data for subjects identified in the question. Once again the importance of talking to the patient, sitting with the patient, spending time with the patient is a major point.

By sitting with them one person sticks out particularly that I just worked with this weekend is just having a terrible time (H.G., interview 12.10)

I know something that I do because of families is like when there is one parent in particular, she will call and she has four children and this is her youngest child that is in here... She will call and we will just talk about how he is doing and I will ask how she is. We will just communicate that way. She wants to let out those feelings. When she comes in I make a point of going over to her and sitting down with her because I feel that is important (J.K., interview 4.17)

I think that it is important to sit and talk with the patient. I see them when they are pre-anesthesia and then I have had a chance where I know the patients personally so I have seen them following anesthesia and I wish I could do that for every patient (D.Q., interview 6.12)

Providing the patient with information was considered an important dimension of ethical practice and functioning as an advocate:
As far as protecting the patient - we had lots of patients go to surgery - who when I would bring them the consent form would say to me, "the doctor didn't explain my surgery to me"; I would say, "don't sign the consent form until he comes in to see you". That happened more than once (L.T., interview 2.14)

Most subjects believed that the most common ethical behavior they engaged in each day was providing the patient with quality care and seeing each patient as a person:

In trying to treat the patient holistically, including families, those ways. I guess in being honest and trying to give the best care you can and knowing when you are not competent to give the best care that I find out what is the best way (F.V., interview 2.15)

I try to encourage them to self-care. I don't want to baby them but I am also there to encourage them to get well and see the dark side. There is a lighter side to the dark side. I try to treat them as a person not as a patient. I enjoy talking with them and interacting with them (M.I., interview 4.10)

I try to do that with my patients each day. It is a little more difficult when you have a heavier patient load but while I am giving morning care I always listen to them, what they have to say or if I am just popping in to check on their IV, I will try to take a few minutes to try to listen to what they are saying (K.F., interview 3.28)

In seeking meaning in these findings, the most significant is that subjects perceived that they were functioning ethically in doing ordinary nursing care. This finding is consistent with subjects' earlier descriptions of ethics in nursing practice. The significance of this finding will be explored more fully under the discussion "section".
The final question of the interview asked the following question:

Of all the important nursing values you have shared with me which one would you select as the most important? Which one would you say was so important to you, you could not practice nursing without it?

The answers to this question are provided in Table 7. One can see that "caring" was chosen the most often with "respect" a close second. An interesting cross-comparison could be drawn at this point between Table 6 and Table 7. It can be determined that while some subjects appeared to be more consistent than others, there was really no inconsistency evidenced. Another way of looking for consistency would be to compare Table 6 with Table 2. This reveals an even more remarkable similarity. For example, the following subjects all identified the same concept in Table 6 as they did in Table 2: EA, JE, KP, JK, MI, AM, PS, LU, FV, and FW. One must be aware that the responses for Table 6 were elicited half-way through the interview while the responses for Table 2 were elicited at the beginning of the interview.

Research Question 7 The final research question addressed the responses to the hypothetical ethical dilemma. The reader may recall that there were two different situations. However, each subject was presented with one. The responses to the situation involving the man with cancer can be seen in Table 8 and the responses to the situation involving the incompetent nurse can be seen in Table 9.
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>FIRST RANKED VALUE</th>
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<tbody>
<tr>
<td>E.A.</td>
<td>Patient's rights</td>
</tr>
<tr>
<td>L.B.</td>
<td>Respect for people</td>
</tr>
<tr>
<td>A.C.</td>
<td>Coordination of care</td>
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<tr>
<td>R.O.</td>
<td>Treat patients like people</td>
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<tr>
<td>J.E.</td>
<td>Safety</td>
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<td>K.F.</td>
<td>Trust</td>
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<td>H.G.</td>
<td>Empathy</td>
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<tr>
<td>J.H.</td>
<td>Caring</td>
</tr>
<tr>
<td>M.I.</td>
<td>Competency</td>
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<tr>
<td>V.J.</td>
<td>Respect and dignity</td>
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<tr>
<td>J.K.</td>
<td>Caring</td>
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<tr>
<td>S.L.</td>
<td>Autonomy</td>
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<td>A.M.</td>
<td>Competency</td>
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<td>S.N.</td>
<td>Caring</td>
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<td>N.O.</td>
<td>Integrity</td>
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<td>K.P.</td>
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<td>D.Q.</td>
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<td>F.V.</td>
<td>Caring</td>
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<td>F.W.</td>
<td>Honesty</td>
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In analyzing the results for the patient with cancer the reader may recall that the recommended sequence of action was to: (a) first clarify the patient's concerns, then (b) talk to the doctor and (c) the family and make a final decision based on evaluation of this information. The ethical principle involved is veracity or truthfulness. If one examines the responses in Table 9, one can see that five out of eleven subjects would begin with the patient. Four out of eleven would begin by talking to the family and two would begin by talking to the doctor. It is also of interest to note of those who would begin by talking to the family only two said they would then talk to the doctor. Another four voiced hesitancy saying "maybe" talk to the doctor, "might" talk to the doctor and "probably" talk to the doctor. In all of the cases the subject would seek more information before deciding what ought to be done in this case. Subjects without exception identified that deception was wrong. No hesitancy was observed in identifying that the patient in question had a right to know the truth. Many students questioned the reason behind the family's decision.

If we now turn to the second situation involving the incompetent nurse, it may be recalled that the ANA's recommendation for the solution of this situation is to begin by talking to the nurse involved and assessing the situation before proceeding to a higher authority. The ethical principle involved is protection of the patient
from incompetent practice (ANA Code for Nurses) so it goes without saying that providing care to the patients is not really part of the dilemma. It is expected behavior. The dilemma involves what to do about the nurse.

If one examines the responses found on Table 8 one can see that of the twelve subjects all but two began by saying that the first thing they would do would be to take care of the patients. This response was interesting because it was highly appropriate under the circumstances and it was not expected. Further examination of these responses reveals that of the ten who would begin by taking care of the patients, seven of them talk to the nurse involved, the other three would go first to the supervisor and discuss the situation. Probably, the most important aspect of these responses is that no one said they would "cover up" for the nurse. Several subjects had difficulty with the situation evidencing a lot of discomfort and hesitancy in saying that they would go to the nurse or go to the supervisor. In fact, only five subjects said that it would "depend" on other factors, i.e., how their meeting with the nurse turned out or what the evidence revealed.

In interpreting the findings with regard to the responses to the hypothetical ethical dilemma the most important finding is that subjects did not perceive a dilemma. Most subjects evidenced a quick solution with very little hesitancy. Subjects appeared to know what needed to be done and the only discomfort a few evidenced
was the sequence of events. What ought they do first? As stated earlier, the situation involving the incompetent nurse appeared to produce greater discomfort and indecision in a few subjects. The indecision was not related to what they ought to do but whether or not they believed they would be able to do it in reality, one subject saying that she would have great difficulty confronting the nurse in question. The important point here is that this particular subject, as in fact all of these subjects did not experience an ethical dilemma about what they ought to do. They knew what the "right" course of action was. The sequence of their actions is not an issue here. Harding (1986) says that in theory, a dilemma is unsolvable but in practice, a solution must be found.

What then is the meaning to be derived from this exercise? One can say with a fair amount of accuracy that all subjects recognized the ethical issue involved and knew what principle was being violated. They also evidenced moral reasoning which is the objective of posing hypothetical ethical dilemmas. This significance of not perceiving an ethical dilemma will be discussed in Chapter 5.

This concludes the presentation of findings. Subjects perceived respect and caring as the ethics of nursing. Respect was described as respect for patient and family, respect for self, colleagues, and the nursing profession. Caring was described as "the little things". The dimensions of caring were described as:
Meeting patients' needs.
Showing love and concern
Going voluntarily to talk to patients
Being cheerful and friendly
Taking time to do "the little things"
Being empathetic and a good listener
Getting involved
Being open and honest
Being a safe competent nurse
Caring was found to be painful and risky

Summary
This chapter began by introducing expert opinion on the presentation of results in qualitative studies. The purpose of this study was to describe how senior baccalaureate nursing students perceived a commitment to professional ethics and further to explore, clarify and describe how these students perceived ethics in practice. The results revealed that these subjects perceived two concepts to be the essence of ethics in nursing. These were the ethic of respect and the ethic of caring. Respect was empirically defined by these subjects in terms of evidence of respect and evidence of disrespect. Respect was categorized into two main subcategories: a) respect for patients and families b) respect for self, profession and colleagues. Respect for patients was described as: 1) respect for the human dignity of the patient and family as person; 2) respect for patient
autonomy and self-determination; and 3) acceptance of patient's and family values. Respect for self, colleagues and profession was described in terms of self-respect as a professional and professionalism in general. Caring was empirically defined by these subjects as having the dimensions of "taking time", showing love and concern, being cheerful and friendly, being a good listener and being a safe competent nurse.

The answers provided to seven research questions supported the existence of two concepts as experienced by these subjects, thus providing corroboration of the significance of these phenomena in the minds of these emerging professionals. The following were additional results:

. The "school" was identified as the most influential force in forming subjects' views of themselves as ethical practitioners.

. Subjects' anecdotal examples of implementing an ethical code were consistent with their earlier definitions of professional values.

. Subjects' perception of nurses in general was not highly positive.

. Subjects' responses to the hypothetical ethical dilemma evidenced moral reasoning and they did not perceive an ethical dilemma.
Subjects were not naive about the "real world" of nursing practice.

Subjects' perception of their futures as ethical practitioners was mostly cautious and conditional.

Chapter 5 presents clarification of these two concepts and what they mean to nursing as evidenced by this sample in particular. The conclusions are presented in the form of an emerging theory of nursing and ethics. Finally, in Chapter 5, the author will discuss the implications of this study for nursing and suggest avenues of further research.
CHAPTER V
CONCLUSIONS, DISCUSSION, THEORETICAL COMMENTARY AND IMPLICATIONS FOR NURSING

Introduction
This chapter begins with a summary of the study and presents the conclusions drawn from the presentation of findings. Discussion of the findings is presented in light of current nursing and ethics literature. The theory is presented based on the major concepts emerging from the data. The major concepts have been empirically defined by the subjects' and an attempt is made to explain the relationships which appear to exist among these concepts. Literature sources are used throughout to delineate and clarify the theory. The final part of the chapter is devoted to a discussion on the relevance of this study for nursing and recommendations are made for further research in this area.

Summary of the Study
The problem was explicated as an apparent discrepancy between the values inculcated through professional socialization of nursing students and the apparent compromising of professional values, which takes place in
the "real world" of nursing care. The purpose of the study was to investigate, describe and explain what senior baccalaureate nursing students internalize as the professional values, and further to describe what they perceive as a commitment to professional ethics in nursing practice.

The sample consisted of 23 senior baccalaureate nursing students from a total population of 120 who were in their final clinical rotation before graduation. Subjects were all volunteers who gave informed consent having been briefed on the purposes of the study, what would be expected of them, the ways in which their confidentiality would be protected and how they would receive the results of the study. Data were collected in three ways: 1) audiotaped interviews; 2) oral responses to a hypothetical ethical dilemma; and 3) written clinical logs. Content analysis was conducted on all data.

Results of the study revealed that subjects perceived two concepts to be central to their view of nursing ethics. These were: 1) respect and 2) caring. Respect was empirically defined by these subjects in terms of evidence of respect and evidence of disrespect. Respect was categorized into two main subcategories: 1) respect for patients and families 2) respect for self, colleagues and the profession. Caring was found to be multidimensional.
Respect for patients was described as: a) respect for the human dignity of the patient and family as person; b) respect for patient autonomy and self-determination; and c) acceptance of patient's and family values. Respect for self, colleagues and profession was described in terms of self-respect as a professional, respect for colleagues and professionalism in general. Self-respect was described as assertiveness, continuing one's education and promoting the rights of the nurse. Respect for colleagues was described in terms of collaborative professional communications. Disrespect was evidenced by "backbiting" and lack of professional unity. Respect for the profession was defined as striving for professionalization, subscribing to the professional values and being involved in the professional organization. Disrespect for the profession was viewed as seeing nursing "as a job" not a career and not evidencing one's knowledge by assuming responsibility for decisions.

Caring was described as being "little things". It was empirically defined by these subjects as having the dimensions of "taking time", showing love and concern, getting involved, being open and honest, being empathic and a good listener being cheerful and friendly, and being a safe competent nurse. Caring was found to be painful and risky.

Conclusions

The following conclusions were drawn based on analysis of data:
A. Respect and caring were perceived as nursing's essential ethics.

B. Subjects' perceived that ethical nursing was evidenced in ordinary everyday nurse-patient interactions and collegial relationships.

C. "Good" nursing was described as respect and caring for patients and families, self, colleagues and the profession.

D. "Bad" nursing was described lack of respect and caring for patients and families, self, colleagues and the profession.

E. Subjects evidenced integration of theoretical ethics in their perception of nursing practice.

F. The "school" was identified as the most influential force in forming subjects' views of themselves as ethical practitioners.

G. Subjects' anecdotal examples of implementing an ethical code were consistent with their earlier definitions of professional values.

H. Subjects' perception of nurses in general was not highly positive.

I. Subjects' responses to the hypothetical ethical dilemma evidenced moral reasoning and they did not perceive an ethical dilemma.

J. Subjects were not naive about the "real world" of nursing practice.

K. Subjects' perception of their futures as ethical practitioners was mostly cautious and conditional
Discussion of Conclusions

A. Respect and caring were perceived as nursing's ethics.

That subjects perceived respect to be one of the two important attributes of nursing ethics is hardly surprising. Ethicists have always considered respect to be integral to ethics (Downie and Telfer, 1970; Green, 1982). Respect for persons is considered to be morally basic by Downie and Telfer (1970:33) who say "...not only is it the paramount moral attitude but also that all other moral principles and attitudes are to be explained in terms of it".

The importance of this finding is not that these subjects perceived respect for persons to be important but that they identified respect for persons to be evidence of "good" nursing. These subjects were not asked specifically to identify the ethics of nursing, they were asked to describe and give examples of what they perceived to be "good" nursing and "bad" nursing. One must recall that the researcher made no attempt to define "good" or "bad". That was left totally to the subject to do through their anecdotal examples. The fact that subjects thought of respect for persons as "good" nursing appears to suggest that ethics had been integrated into their concept of nursing.

If one reviews the data which support the category of respect and its subcategories, one cannot fail to be somewhat surprised that the data should support three main subcategories of respect. These subcategories are very
similar to those which philosophers have explicated for centuries. Moral philosophers, Downie and Telfer, describe respect for persons as 1) respect for the person because of their humanity 2) respect for a person's autonomy and 3) respect for the "rules" which they live by. Perhaps the subjects are saying: "I know what respect for persons is and here are some examples of it in nursing." Yet one must constantly be reminded that the subjects were not asked for examples of respect for persons, they were asked for examples of "good" nursing. This finding suggests that the subjects had internalized the value, respect for persons, as integral to everyday nursing practice.

The perception of caring as a nursing ethic is surprising. Although students' familiarity with this concept is in no small way related to their nursing education, its connection with ethics is not apparent in the nursing ethics literature. One of the difficulties is the recognition of caring as a moral duty. Nursing ethicists are fairly consistent in their view of the guiding moral principles which are usually identified as: Respect, beneficence and justice. The ethical principles of autonomy and veracity are incorporated under respect. If one reviewed the ANA Code For Nurses one becomes aware that the concept of caring is not included. The word 'care' appears once as in health care. Moreover, if one reviews the ICN Code For Nurses it becomes apparent that while the term 'care' appears four times, the concept of
caring is not included. The question now becomes, with so little connection between caring and ethics in the nursing ethics literature, why have these subjects made this conceptual leap? In order to attempt to answer this question it becomes necessary to examine the concept of caring.

The importance of caring as the essence of nursing has been discussed by Leininger (1977) and Watson (1979). However, these have almost exclusively relied on conceptual and philosophic definitions of this concept. Recently, there have been at least two attempts to develop an empirical definition of this concept. Gardner and Wheeler (1981) attempted to identify nursing behaviors that were viewed by both nurses and patients as supportive. In this study the method was quantitative and the investigators used a structural interview and a questionnaire to collect data. Statistical analysis was used. The results revealed that three behaviors were ranked highest by patients as evidence of support from nurses. These were in descending order: 1) nurse helped me to feel confident that adequate care was provided; 2) nurse was friendly; 3) nurse showed interest in me. The three behaviors identified by nurses were in descending order: 1) show interest in patients; 2) create an environment where a patient feels free to express feelings; and 3) take time to listen to patients. It is interesting that patients perceived different things as more important than did nurses. It is also interesting
that what nurses perceived as most important is very similar to what the subjects of this study thought most important. A final word of caution is needed. The subjects in the Gardner and Wheeler study were presented with a list of possible behaviors. One needs to consider what they would have said had they just been asked without the limitations of a list.

In another attempt Reimer (1986) conducted a phenomenological study with the purpose of explicating the concept of "caring" and "noncaring" through analyses of patients' descriptions of these concepts. Reimer found that females viewed "caring" somewhat differently than men did. The ways in which caring was described are as follows:

Female

1. Nurse really listened to what the client said, responding to the individual's uniqueness.
2. Nurse was perceptive and supportive of client's stated and unstated concerns.
3. Nurse's physical presence of sitting, talking, direct eye contact, holding hands and being self-disclosing, made the client feel free to talk.
4. Caring interactions (encompassing behaviors and attitudes) made the client feel like valued human beings and not like inanimate objects or things on display.
5. Nurse's voluntary and unsolicited return to the client was highly indicative of a caring attitude.
6. Individualized concern for the client made the client feel comfortable, secure, at peace, and relaxed.
7. The soft, gentle voice and mannerism impressed the client as caring and nonthreatening and nondegrading.
8. The security felt by the client when in a caring interaction invokes feelings of being well taken care of by a family member.
9. Caring encounters evoked warm feelings in the client of wanting to do something reciprocal for the nurse.

Male

1. Nurse's physical presence of sitting, talking, holding hands, made client feel the nurse was truly concerned with him as a valued individual.
2. Nurse's voluntary and unsolicited return to the client was seen by the client as highly indicative of caring.
3. Nurse's caring made him feel comfortable, relaxed, secure, and in good hands, as though he was being taken care of by a family member.
4. Attention by the nurse to comfort and needs of the client before doing nursing "tasks" was interpreted by the client as caring.
5. A kind, soft, pleasant, gentle voice and attitude impressed the client as being caring and nondegrading.

A brief analysis and comparison of the themes found here and the themes described by the subjects of the present study reveal certain common threads. First, physical presence of sitting, talking, holding hands was highly ranked by both males and females. Second, nurses voluntarily returning was considered caring by both male and female, and the nurse's manner while interacting was considered very important. Again, we are aware of the close comparison between the views of caring and those of the subjects in the present study.

Reimer's description of noncaring behaviors are also very interesting. These are also presented below:

Female

1. The nurse's actions of always being in a hurry, without taking time to really talk or listen are indicative to the client of the
1. The nurse's lack of interest in him or her as an individual.
2. The nurse's attitude of lack of interest in him or her as a person is interpreted by the client as the nurse viewing nursing as only a "job".
3. The nurse's physical actions and manner of speaking that belittle and degrade, are seen by the client as noncaring.
4. The physical behaviors exhibited by the nurse of being cold, tough, super-efficient, rigidly following rules, avoiding eye contact, not offering explanations, seeing only parts of the client results in the client feeling frustrated, scared, depressed, angry, afraid, and upset.

Male
1. The nurse who does not pay any attention to the client's needs, but views nursing as a job, is perceived by the client as noncaring.
2. The physical absence or only short superficial appearance of the nurse, is interpreted by the client that the nurse does not consider him or her to be of any importance as a human being.
3. The cold voice and rough physical actions of the nurse are interpreted by the client as his or her being treated as a nonhuman subject or as an inanimate object.
4. The verbal and physical communication from a nurse which makes the client feel like a bad child is insulting and degrading and makes the client feel helpless and frustrated.

In these behaviors we become aware of the significance of "taking time" which is a theme frequently described by the subjects in this study. Yet, there is something else evidenced here: the patient's perception of being treated as a "thing", not a person, being belittled and the nurse acting as though he or she didn't really want to be there. In the present study, these characteristics of behavior were viewed as disrespect for the patient as a person which the subjects appeared to be saying respect preceded caring in the nurse-patient relationship. One can see
that further research is required in order to clarify and describe these two concepts not only from the nurses' points of view but also the patients'.

A brief review of the attributes of caring described by the subjects of the present study reveals that caring was not merely perceived as an emotional dimension of nursing. These subjects perceived "caring" as an ethical dimension in that it encompassed the ways nurses ought to conduct themselves. Subjects perceived that "caring" was an ethical standard for nurses. This is further evidenced by the answers received to the last question of the interview in which so many subjects identified "caring" as their highest ranked professional value. Carper (1986:1) also makes the connection between caring and ethics. In discussing the criticism to which health care workers have been exposed she says:

This basic dictum to be compassionate, humane and caring toward those for whom we provide care is most often expressed in the phrase "treat the person not merely the patient". To be concerned with the "whole person" and to practice with consideration and sensitivity for the integrity of the human self is basically an ethical injunction.

The importance of "caring" to the subjects was further verified when subjects were asked to say what kind of nurse they believed themselves to be. They were also asked to consider what their patients would say about them and incorporate this into their self-description. The number of subjects who described themselves in terms of "caring" or in terms of caring behaviors was very
revealing and added greatly to the evidence in support of "caring" as a primary ethical concept.

B. Subjects perceived that ethical nursing was evidenced in the ordinary everyday nurse-patient interactions and colleagueal relationships.

That these nursing students should identify the mundane and the ordinary as the focus of ethical nursing is somewhat surprising since the ethics experts in nursing appear more concerned with the extraordinary. A review of the nursing ethics literature will reveal that the emphasis is on situational and ethical dilemmas. A perusal of a nursing ethics bibliography (Pence 1986) evidences that, of the categories identified, the largest categories are in the following areas: Doctor/Nurse/Patient Relationships; Death and Dying; Professionalism, Codes and Disciplines; Human Experimentation; and, The Nurse and the Law. It may be of interest to note that the smallest category, consisting of seven articles, was entitled "Caring and Compassion". It is also somewhat significant that the word "respect" does not appear once in any of the article titles.

How is one to interpret these phenomena. Possible explanations are that those who write nursing ethics articles do not practice nursing, or perhaps, articles about respect and caring are not considered interesting enough. Another possibility is that nurses in general are
not as conscious of these concepts, or lack thereof, as were these emerging professionals. It is possible that practicing nurses deny the extent of patient depersonalization because to acknowledge it would be too threatening to their psychological health.

C. "Good" nursing was described as respect and caring for patients and families, self, colleagues and the profession.

The significance of these findings may be obscured by their apparent simplicity, and by the current emphases on technology and behavioral competence. Is that all there is to good nursing? The statement is deceiving. It appears to be simple but one may as well ask "why is it so difficult to be moral?" Why is it difficult to show respect in daily interactions, to be courteous, to care that a person is in pain, to care about patients' problems, to speak up when rights are being violated?

Silva (1983) describes nursing as a duty, a moral art and an autonomous profession. Her thesis is that nursing owes society a duty to care because society and nursing have a social contract. She describes the moral art of nursing as taking care of patients by touching, teaching, comforting, listening, diminishing suffering and generally doing for persons what they cannot do for themselves. In describing nursing as autonomous, Silva says the greatest threat to autonomy comes from within the profession—From nurses who do not appear to have confidence in their
professional knowledge and who seek answers to nursing care problems from physicians.

The findings in this study lend support to Silva's position. Nursing involves a very personal service to persons often at the most critical times of their lives. One needs to consider for a moment that very few nursing activities do not involve an ethical dimension. The very busy nurse decides not to bathe the unconscious patient. There is a shortage of linen. Whose needs are served, the demanding Mr. Brown or confused Mr. Smith who keeps spilling his urinal in the bed? The food trays come up but there's no one to feed Mrs. Jones. Nurses are very often torn by conflicting demands. A case in point. Nurse B. has become aware that Mrs. W. is a very frightened woman; she knows that she ought to spend some time with her, but Mr. C. has an I.V. and a new solution needs to be hung. Nurse B. prioritizes and goes to the nurses station to get the solution. At the nurses station, Nurse K. asks Nurse B. to help her get a heavy patient out of bed. Nurse B. says yes but after s/he has hung the solution. Mr. W. has some concerns about his ability to return to work after his surgery, he could use some support, but first the patient that needs to be gotten out of bed. Nurse B. is on her way to help Nurse K. when s/he sees that Mrs. Jones is almost out of bed and is hanging over the side rails almost strangled by her restraints. This hypothetical hour in the life of a hospital nurse is not as farfetched as one might imagine.
One can imagine the stress of Nurse B. How is s/he to meet all the demands being placed upon her? What are the coping mechanisms used to withstand this ever present pressure?

Studies reveal that dissatisfaction with working conditions is by far the major reason for voluntary turnover among hospital nurses. (Kelly, 1979) One could easily speculate that Nurse B. may become mechanical under such conditions -- going through the motions, seeing nursing in the words of one of this study's subjects as "so many tasks that need to get done." Yet, there is yet another factor which is, potentially more damaging to the mental health of nurses, that is the cognitive dissonance which is precipitated by the incongruity between the reality of practice vs. the values professed by the nursing profession.

Carrol and Humphrey (1979) see a basic inconsistency between the principles outlined in the ANA Code For Nurses and reality: They provide as an example an excerpt from the Code with Interpretive statements, "quality health care is mandated as a right to all citizens". These ethicists assert that a claim such as this evidences "a certain blindness to reality" Fry (1985) discusses the ethical tension created by the nurses' commitment to an individualistic ethic, as in treating each person with respect, vs. the aggregate ethic of promoting the greatest good for the greatest number. Melia et al (1983:9) have said:
"The values and principles which we hold as individuals or groups cannot be studied in isolation from those of the society and culture which have made us what we are."

Few would deny that profit-making is an important value in this society yet one needs to question if health care institutions ought to function for this purpose. The point is that nurses are caught in the middle, often working in institutions whose emphasis is cost-effective, task-oriented efficiency while at the same time claiming that the patient is the most important person. Nurses are educated to believe in the principles of the ANA Code For Nurses only to find, in reality, patients are very powerless and are rarely included in the planning of their health care. Nurses are educated to believe that nursing has a unique body of knowledge which will be consulted on patient care only to find out that many physicians think that nursing is a subdivision of medicine and that they are the "real" experts on nursing care. These are some of the "realities" which confront the emerging professional. How are these new members to "hang on" to their professional values and withstand the pressure to conform to the existing system. McCloskey and McCain (1987) found that when the expectations of new nursing graduates were not met there was a decline in satisfaction, commitment and professionalism in the first six months of nursing practice. It would appear that a vicious cycle is occurring in nursing practice, new graduates receiving
little support in maintaining their professional values. The pressure to conform to the system is overwhelming so that these same professionals become part of the system and contribute to the continuation of the problem.

D. Subjects perceived "bad" nursing to be lack of respect and caring for patients and families, self, colleagues and the profession.

The evidence provided by the subjects regarding what the viewed as "bad" nursing corroborates the authenticity of the categories. The data reflect actual experiences in which subjects perceived that in one sense patients are depersonalized, becoming the "they" that "we" have to deal with and in another sense are the central focus of gossip.

While the findings of this study with regard to nurses gossiping about patients is cause for concern, the essential question that needs to be addressed is, why is it occurring? Is this behavior a reflection of unprofessionalism in nursing? The subjects indicated that they thought so. What is of even greater concern it would seem is the apparent view of patients as depicted in comments such as: "you have to treat them this way or they won't mind" as well as nurses' perception of patients as being "manipulative" and "out to get them." It is very difficult to understand the cause of such phenomena. One could speculate that when people are under great stress, paranoia is a frequent symptom. Yet, the other question is: Why are such problems not addressed in
the nursing literature? Surely these problems involving basic respect for persons are not confined to one area. The ethics literature appears to be almost totally directed at helping nurses to resolve problems of situational as well as ethical dilemmas. While it is acknowledged that "washing one's dirty linen" in public is a very painful process, not facing the problem is even worse since it is evidence of self-deceit with the profession.

Subjects' perception that "bad" nursing was also evidenced by lack of self-respect and gossip about one's colleagues provides evidence of the holistic nature of nursing ethics for these students. Evidently these students perceived ethics globally and not associated only with patients as is most often presented in the nursing ethics literature. While there is reason to be concerned about the gossiping and "back biting" that appears to go on, one needs to be even more concerned by the evident lack of caring that is demonstrated by this behavior.

One should not have to be reminded that nursing is a caring profession. Yet, the data reveal that these subjects perceived a lack of caring. Not only was this evidenced by subjects' oral perceptions but in written logs as well. It appeared as though grief was handled by each "in her/his own way". There was no apparent group recognition of each other's grief. Students' evidenced confusion regarding their feelings: "Is this how I'm supposed to feel? Why is there no group effort to
recognize feelings of sadness and pain? Is this a gap in nursing education?"

Finally, it would appear that subjects are saying that veteran nurses view their younger colleagues' idealism and enthusiasm in a patronizing manner. One subject said, "they tell me I won't last." Another inference is found in the saying, "we don't do it like that here that only happens in school". One becomes aware that there appears to a general conspiracy on the part of many veteran nurses to resocialize new recruits away from the knowledge and skills learned in schools. If one attempted to reason why this happens one might perhaps reconsider that such practices; 1) serve as an initiation rite; 2) nurses are threatened by the new nurses' considerable knowledge base, or; 3) it's a coping mechanism to protect themselves from the memory of their own lost ideals. In any case, it is a very divisive force interfering with the emergence of a professional self-concept and image of the profession.

These nursing students were able to articulate their "reality shock". They were conscious of conflict, and some evidenced this in the data. The question is: How long will they hold out against these opposing forces?

E. Subjects evidenced integration of theoretical ethics in their perceptions of nursing practice.

Although these students were not asked to identify either the Code For Nurses or ethical theory, it appears
as though they were functioning in accord with the principles outlined in the ethical Code. In fact, one could show that there was a strong relationship between the self-proclaimed values of this group and the Code For Nurses. Had these subjects been asked to identify the eleven principles of the Code the chances are that they would not be able to do it. Yet, in practice they appear to be implementing it. It would appear that they had integrated ethical principles to the extent that ethics and nursing were inseparable.

F. The school was identified as the most influential force in forming subjects' view of themselves as ethical practitioners.

The importance of the "school" as the most important influencing force, impacting on their present view of themselves, is hardly a surprising finding. However, what was surprising of to the investigator was the lack of more evidence supporting the influence of specific role models or mentors. Another surprise was how evidently little influence the clinical settings appeared to have. It should be noted here that while students were given a choice of where they wished to be placed for their final clinical experience, the majority chose hospital settings. The rationale was that their first job would most likely be in a hospital. Another item also worth mentioning was that subjects seemed to be proud of their program because it "wasn't easy". It appeared as if they were saying, "It
was tough, I survived and I'm a better nurse and person because of it." Much of this was associated with professionalism.

Subjects' linkages of "good" nursing with proper professional behavior was a strong theme throughout the data. Yet subjects articulated much of this connection as respect for self as a professional nurse, and respect for the profession. Subjects really valued "professional" behavior. They seemed to be saying that professional behavior was ethical behavior and vice versa. Another important insight into these data is that subjects also seemed to perceive that many nurses in their experience did not act professionally, indicating that many nurses acted as though nursing was just a job and not a career. These subjects also tended to dichotomize nursing into "us" and "them", many linking their concept of "professional" with certain good nurses they knew. Very frequently this person was identified as either their clinical instructor or preceptor. Many also linked professionalism to their role models' education. Preceptors were required to have a baccalaureate degree.

It seems important to add here that subjects on the whole felt very positive about their preceptors, many identifying the way in which these nurses interacted with their patients or the ways in which they performed their nursing tasks. Yet, when these subjects were asked to identify the influences which had most impacted upon their
view of themselves, as nurses, they did not identify their preceptors. This leads one to speculate that perhaps subjects perceived their self-concept to be already formed prior to their Role Transition experience. This area requires further research.

G. Subjects' anecdotal examples of implementing an ethical code in practice were consistent with earlier definitions of professional values.

When asked to provide the investigator with specific examples of how they believed they were implementing an ethical code in practice, these subjects stayed very much true to their original concept of professional values. Those who had identified professional values as accountability gave examples relating to competence or professional responsibility. Likewise, subjects who had identified patient's rights gave examples in this area. Subjects who had identified honesty as part of their definition for professional values gave examples of their own confessions in making mistakes and owning up to it. Subjects who listed quality of care gave examples of caring. One subject who identified patient safety continued to provide consistent evidence of this throughout the data. There was evidence of this not only in the interview data but a remarkable consistency between data provided in interviews and log data. Quite often the same anecdotal examples were either provided in more detail in the logs or somewhat less.
H. Subjects' perception of nurses in general was not highly positive.

A certain amount of concern should be felt that these subjects were so critical of many of the nurses they had known. Questions raised by this phenomenon are, how does this view of nurses affect their view of themselves in particular and their view of the profession in general? I believe psychologists would say that this state of affairs would tend to impact on their self-concept as nurses and their perception of the profession. It would appear that much more research is required with regard to this phenomenon. It is important to state here once again that several in this group of subjects characterized many nurses as:

* not caring
* not professional in their interactions
* sloppy and careless endangering the lives of their patients
* not taking risks
* not speaking up on the patient's behalf.

While it is only fair to point out that several subjects were highly positive in their remarks, the fact remains that the many of these subjects perceived their nursing colleagues with a critical gaze.

I. Subjects' responses to the hypothetical ethical dilemma evidenced moral reasoning and they did not perceive a dilemma.

With regard to subjects' responses to the hypothetical ethical dilemma, the subjects did not, for the most part,
appear to have experienced a dilemma. Most subjects evidenced a quick technical "solution" with very little hesitancy. Subjects appeared to know what needed to be done and the only discomfort a few evidenced was the sequence of events. What ought they do first? As stated earlier the situation involving the incompetent nurse appeared to produce greater discomfort and indecision in a few subjects. The indecision was not related to what they ought to do but whether or not they believed they would be able to do it in reality, one subject saying that she would have great difficulty confronting the nurse in question. The important point here is that this particular subject, as in fact all of these subjects, had no question about what ought to happen in the case. This is of vital importance because White (1983) would say that each of these cases were not really ethical dilemmas but merely situational dilemmas. This is pointed out here because the nursing literature supports both of these situations as being ethical dilemmas for nurses.

White, in writing about what she calls the "overblown ethical dilemma" says that not every situation in which a nurse holds a different opinion from that of the physician or patient is an ethical dilemma. Calling it the "nurse-in-the-middle" situation she says that only when the nurse is aware of very strong reasons for providing the patient with information and equally strong reasons for not providing the patient with information is it really an ethical dilemma.
It has occurred to this researcher that the dilemma for these subjects with regard to the patient with cancer should have begun with..."the patient's family have told you that he has always been terrified of cancer, and they believe he would not be able to live with it. What would you do?"

Likewise, turning our attention to the situation involving the nurse, White would say that there would need to be strong ethical reasons aside from lack of courage, for not reporting this nurse. It may be that many "ethical dilemmas" are not and that White is quite right when she says that, "the developing literature in nursing and ethics...reveals a state of considerable confusion". White also takes exception to what she calls "formula ethics", by which she means that ethicists have gone so far as to suggest specific formulas for resolving ethical dilemmas.

R.S. Peters (1967) has attempted to show that the practice of moral discourse loses its point if some kind of respect for persons is not presupposed, which leads one to wonder if the question, "What should I do?" often evidences greater concern for self-interest than respect for the persons involved. All too often we hear of situations in which the fate of individuals are debated by ethics committees and staff conferences, yet, no one has thought of consulting the person as to what he or she wishes. Peters (1967:132) clarifies this form of disrespect for persons as follows:
When it is said that a man who brainwashes others, or who settles their lives for them without consulting them shows lack of "respect for persons", the implication is that he does not treat others seriously as agents or as determiners of their own destiny, and that he disregards their feelings and view of the world. He either refuses to let them be in a situation where their intentions, decisions, appraisals, and choices can operate effectively, or he purposely interferes with or nullifies their capacity for self-direction. He ensures that for them the question "What ought I do?" either scarcely arises or serves as a cork on a tide of events whose drift derives from elsewhere. He denies them the dignity which is the due of a self-determining agent who is capable of valuation and choice and who has a point of view of his own about his own future and interests.

These subjects felt strongly about self-determination and equally strong about the principle of veracity, many saying deception is wrong. In the case of the patient with cancer some subjects debated that perhaps since his family knew him best that there might be reasons as to why his knowing might harm him. Kant would disagree with this reasoning and would argue that lying for any reason is morally wrong. Kelly (1987) says Kant was intransigent in his condemnation of deception. He goes on to say that Kant, in writing his famous article, "On a Supposed Right to Lie from Altruistic Motives," focused the duty of truthfulness as a legal duty. Nell (1975) in her assessment explains Kant's views on deceit. She says that lying in order to protect a person is deceiving oneself. She says, "Someone who is shielded (from the truth) is not treated as an equal. This would appear to provide support for the position that paternalism is morally wrong."
J. Subjects were not naive about the "real" world of nursing practice.

It has been said that nursing students are unaware of the realities of nursing until they graduate (Kramer, 1975). Yet, these subjects evidenced much clarity in articulating "reality". A review of the literature reveals that they were often on target. Two of the most frequently cited causes of disillusionment are the patient load and the lack of autonomy in hospitals. Subjects appeared to be saying that they were well aware of the staffing constraints and the need to prioritize their time. It is interesting to note here that while subjects provided evidence of the stress experienced in the clinical settings due to patient load (subjects' logs, 1987), none listed inadequate staffing as "bad" nursing. It appeared as though these subjects perceived "bad" nursing as being related to individual responsibility and accountability. The failures of hospital administrators did not surface.

Many subjects linked poor staffing with "bad" nursing. One may recall S.L. saying that a particular nurse "because of high patient load" did not check on a patient all day. There were several in examples which "good" nursing was linked to patient load. Another subject said, "You can't practice competently when you have too many patients." (F.V., interview, 3.16) Another subject responded to the question on implementing an ethical code by saying, "It's a lot easier when I don't have so many
patients." (K.F., interview) Yet another said that patient load was very stressful while still others talked about time as a constraint, meaning an obstacle to performing according to their own standard. It should be noted here also that approximately half said that a lot depended on where they chose to practice, meaning not only the institution but also the geographic region. Perhaps this was a reference to their knowledge of the incredible variance in nurse practice acts. In fact, two subjects specifically mentioned this concern.

Patient load is of continuing concern to hospital nurses. A review of the nursing literature will verify that the most frequently cited causes of dissatisfaction among hospital nurses are, lack of recognition from administration, inadequate staffing patterns and the patients." (K.F., interview) Yet another said that patient load was very stressful while still others talked about time as a constraint, meaning an obstacle to performing according to their own standard. It should be noted here also that approximately half said that a lot depended on where they chose to practice, meaning not only the institution but also the geographic region. Perhaps this was a reference to their knowledge of the incredible inability to withstand the stress associated with the responsibility of attempting to give quality care to too many patients without sufficient resources. (Kelly, 1979) This has been the same pattern in hospital nursing
throughout its history (Kalisch and Kalisch, 1986). The logical question is, how do hospital administrators continue to get away with it? Are there perhaps reasons not yet explored as to why hospitals mistreat nurses? Ashley's (1976) historical account of the relationship among hospital administration, physicians' power and the role of the nurse was the first of its kind to explore the apprenticeship system and exploitation of women in servitude to American hospitals. Lovell (1986) explores the relationship between medicine and nursing and concludes that a symbiotic relationship exists which is destroying nursing through deception, paternalistic hostility and blatant sexism. She says nurses are enamored by the medical model and do not question their oppression.

The oppression of nurses by physicians and hospitals is not a new concept in nursing literature. A review of nursing history will reveal that nursing has always been the main service offered by hospital which has always been viewed, in America, as a lucrative business venture. Nurses were the cheap labor force and still are. The problem with oppressed groups is that they believe nothing can change. It is the biggest advantage the oppressor has. (Freire, 1982)

Why do nurses continue to put up with conditions which are inhuman and dangerous? Is there perhaps something else? Have nurses as mostly women internalized the "mother complex" of "making do" under extreme
conditions?. Do they perhaps envision that if they don't complain that they will be rewarded in some way? "Look, I just took care of ten patients all by myself and I didn't harm anyone. Aren't you proud of me?" But one is not talking about an obstacle race or who can do the most with the least. The problem is that it is not the nurses' endurance that is in question. Rather, the lives of patients, who are not receiving the care that nurses are qualified to provide, are at stake.

K. Subjects' perception of their futures as ethical practitioners was mostly cautious and conditional.

Subjects perceived their future in terms of what they could control and what they could not. They could control where they worked and this was identified as very important. They believed they had some choices. This is true due to the nursing shortage. They appeared to have evaluated their prospective employers on the basis of opportunity for professional growth and professional autonomy. The concept of control or power was evident in student discussions, some acknowledging feeling a lack of control over the staffing issue. Most mentioned patient load as the biggest obstacle to ethical practice.

A reason for concern was the number of nursing students voicing a negative view of physicians. This is viewed with concern because as professionals they will work closely with physicians. It would appear that
beginning their career with a negative perception would tend to influence their interactions in the future.

Clearly, senior nursing students know a great more about the "real" world of nursing practice than was previously supposed. However, one must take into consideration that these particular students were experiencing "reality shock" while still students mainly because of their Role Transition course, geared to assist the graduating senior make the transition from student to nurse. It also appears that despite faculty support and the support of a preceptor many of these students experienced a great deal of stress and anxiety. One can only imagine what they would undergo had they not had this experience.

The problem which precipitated this study was delineated as a discrepancy between nursing, as expounded by the profession in the form of the Code for Nurses, and the practice of nursing as portrayed by the general staff nurse. It appears that this study has added further support to the suspicion that there is an ever-widening gap between the idealism of the educational setting and the reality of the practice setting. These issues will be discussed further under implications for nursing practice, education and research.

Theoretical Commentary
Finding theoretical meaning in the results of a study is not as simple as Glaser and Strauss would have one
believe. This investigator found the prospect to be an incredible responsibility.

There are probably as many definitions of what constitutes theory as there are views on ethics. However, a few of these definitions have been selected to provide a working definition of this concept. Stevens (1979:1) says, "a theory is a statement that purports to account for or characterize some phenomenon". Field and Morse (1985:2) say that "a theory is a hunch, a guess, a speculation or an idea that may explain reality". Silva (1983) says, "Theory is a set of related statements which have been derived from scientific knowledge and philosophical beliefs from which plausible hypotheses can be deduced, tested and verified." In qualitative research, theory should emerge from empirical data. Patton (1980:278) says:

The cardinal principle of qualitative analysis is that causal relationships and theoretical statements be clearly emergent from and grounded in the phenomena studied. The theory emerges from the data; it is not imposed on the data.

With these thoughts in mind the following assumptions form the basis of the theory emerging from this study:

1: The practice of nursing is essentially moral in nature.

2: Respect for persons and caring are the ethics of nursing.

3: Respect, as a nursing ethic, is evidenced by respect for patients and families, self, colleagues and the profession.

4: Caring, as a nursing ethic, is evidenced by caring for patients, self, colleagues and the profession.
5: Respect and caring are necessary but not sufficient properties of nursing.

6: Respect precedes caring in the nurse-patient relationship.

7: In the absence of respect caring cannot take place.

8: In the absence of caring nursing does not exist.

Assumption 1: The practice of nursing is essentially moral in nature.

To find support for this view one need look no further than Florence Nightingale who is perceived to be the founder of modern nursing. Nightingale saw nursing in her own life as a "call from God" (Woodham-Smith, 1957). On May 29, 1900, she wrote the following letter to her probationers at St. Thomas' Hospital:

My dear children:

You have called me your Mother-Chief. It is an honour to me and a great honour to call you my children. Always keep up the honour of this honourable profession...We dishonour (it) when we are bad or careless nurses, we dishonour (it) when we do not do our best to relieve suffering even in the meanest creature. (Schuyler, C. 1975)

And again, she commented to her probationers:

We know no one calling in the world, except it be that of teaching, in which what we can do depends so much on what we are. To be a good nurse one must be a good woman. (Schuyler, C. 1975:166)

The history of nursing provides support for the notion that nursing is essentially a moral activity. Prior to the influence of Nightingale nursing was provided by religious orders as one way of meeting moral obligations. The Bible recounts the parable of the Good Samaritan as an
example of moral obligation to our neighbor: the history of American nursing is replete with examples of women who risked everything to focus their lives on service to others. Ministry to the needs of others is the essence of nursing.

**Assumption 2:** Respect for persons and caring are the essential ethics of nursing.

This statement is well supported by data in this study. However, it can be shown that there is much wider support for such a view. The problem, it would appear, would not be an argument about respect for persons as a fundamental ethic of nursing. Most readers, however, would want to know how "caring" fits into an ethical framework. The definition of ethics or "an ethic" has already been addressed in this study, yet a reiteration at this point would not seem redundant.

Ethics is "a branch of philosophy relating to human conduct with respect to the rightness or wrongness of certain actions and to the goodness and badness of the motives and ends of such actions" (The Random House College Dictionary, 1972). The ethics of nursing then would refer to the conduct of nurses while they are nursing and to the motives and ends of their professional decision-making. The author will begin the defense of the above statement by an examination of the principle of respect for persons as it relates to nursing.

**Respect for persons.** Downie and Telfer (1970:28) describe the components of respect for persons as follows:
In so far as persons are thought of as self-determining agents who pursue objects of interest to themselves we respect them by showing active sympathy with them; in Kant's language, we make their ends our own. In so far as persons are thought of as rule-following we respect them by taking seriously the fact that the rules by which they guide their conduct constitute reasons for which may apply both to them and to ourselves...These two components are independently necessary and jointly sufficient to constitute the attitude of respect which it is fitting to direct at persons...

Kelly (1976) says, "the true ethics of all health care codes are based on the rights and dignity of individuals - treating the patient as a person". The first ethical injunction of the Code for Nurses speaks to the provision of respect for all humans. Curtin (Curtin and Flaherty, 1982:3) has consistently pointed out that ethics in nursing is more evidenced by the day-to-day activities among nurses and patients than "fabulous life and death issues". She goes on to discuss an example which she says "represents the daily disrespect to which patients are subject".

Caring The connection between caring and ethics was made by Gilligan (1979). She described a model of moral development for females which is based on caring. Gilligan felt that females have had to develop a sense of responsibility based on the universal principle of caring in order to survive. Noddings (1984) also proposes a feminine view of ethics based on caring. Her argument is that what forms the basis of all moral action is the memory of being cared for. Her belief is that all moral
decisions are grounded in natural caring. This view of ethics is not unlike the psychological view that one needs to be loved in order to love. Montagu (1975) says..."she knows how to love, for the only way one learns how to love is by being loved".

The question remains, however, is there a moral injunction for nurses to care? To answer this a brief examination of the philosophical explication of "care" or "caring" is necessary. The dictionary definitions of "care" and "caring" clearly reflect different uses of "care". Care may be equated with mental suffering, a state of being concerned about someone or to be charged with the protection of someone. The idea that "caring" involves some element of personal giving of oneself or sacrifice has been discussed by philosophers. Downie and Telfer describe this as an "active sympathy" with others and call it "agape." Mayeroff (1971) identifies the major ingredients of caring as: knowing, patience, honesty, trust, humility, hope and courage. His views are paraphrased as follows:

**Knowing.** To care for someone one must know who the person is, what his/her powers are, what his/her needs are and what is conducive to his/her growth. One must also know what one's own powers and limitations are.

**Patience.** Mayeroff says that patience involves giving time to others and actively participating with others.
Honesty. To be honest one does not deceive others. One does not pretend. There must be a congruence between what one feels and how one acts.

Humility. According to Mayeroff the person who cares is always willing to admit that there is something more to learn. They have a realistic appreciation for their powers and limitations.

Hope. The caring person is always conscious of potential for growth.

Courage. The caring person is a risk-taker. They know that there are no guarantees. Mayeroff says that such courage is not blind but has its roots in past experience but is open to the future.

Gaut (1983) in explicating a theoretical definition of caring identifies five conditions for "caring" to take place. These are:

First condition: S must be aware, either directly or indirectly of the need for care in X.

Second condition: S must know that certain things could be done to improve the situation.

Third condition: S must intend to do something for X.

Fourth condition: S must choose an action intended to serve as a means for bringing about a positive change in X, and then implement that action.

Fifth condition: The positive change in X must be judged on the basis of what is good for X rather than S or some other Y or Z.

In briefly analyzing this view of caring one can say that Gaut believes that: 1) knowledge of the cared-for is necessary; 2) hope is necessary; 3) intention to act is necessary; 4) a "proper" action has been identified and implemented by the care-er; and 5) a judgment is made by
the care-er that the positive change is what is good for the cared-for. What is not clear, however, is the role of the cared-for. Does X have a voice in the action intended to bring about "this positive change"? This raises the question of what part the cared-for plays in "caring".

Mayeroff says that care-er and cared-for exist on the same level. They exist in equality. Noddings (1983) also refers to equality in the relationship between adults but also describes how the cared-for may not be able, because of developmental maturity or other reasons, to respond in the same way to the care-er. But Noddings insists that response is required on the part of the cared-for in order for the relationship to be one of caring. "Response" was not defined.

To return to the question of caring as an ethical obligation for nurses, one needs to recall the philosophical definition of caring. Caring is philosophically defined as being concerned, involved, having an active sympathy which manifests itself in supporting the cared-for's goals for growth and self-actualization. Rollo May (1969) says the opposite of caring is apathy or indifference. Miss Nightingale considered this latter attitude to be responsible for the greatest evils in the world. She wrote:

I think very little of the sin commonly called immorality compared with brutal indifference, the stupid selfishness, the miserable vanity which makes the world what it is...We have seen terrible things in the last three years, but nothing to my mind so terrible as Parmure's
unmanly and stupid indifference. (Schuyler, 1975:90)

Nightingale exemplified caring throughout life. Her efforts to comfort soldiers in the Crimea are well documented. (Woodham-Smith, 1957) She was tireless in her attendance of the wounded. One soldier wrote home saying, "She always has her own special patients and those the worst cases, and she often sat up until all others were asleep." She continued to care about the people of India and was again tireless in her efforts to promote health in India. She wrote:

We do not care for the people of India. Do we even care enough to know about their daily lives of lingering death from causes which we could so well remove? We have taken their lands and their rule and their rulers into our charge for State reasons of our own. But for them themselves - these patients, silent, toiling millions of India, who scarcely but for suffering know their right hand from their left, and yet who are so teachable, so ready to abide by law...should we not as a nation practically rise en masse to see that the remediable things to which good public servants have so often vainly called attention shall be remedied. Have we no voice for these voiceless millions? (Schuyler, 1975:113)

Are nurses ethically obligated to "care" for their patients? The subjects in this study support the affirmative. Historical evidence testifies to the fact that Miss Nightingale cared and believed that "caring" was a moral obligation for nurses.

Assumption 3: Respect, as a nursing ethic, is evidenced by respect for patients, respect for self, colleagues and the nursing profession.
Respect for patients has the following components: 1) Respect for the dignity and uniqueness of patient's and families; 2) Respect for patient autonomy; and 3) Acceptance of patient's values.

While this study has devoted much time describing respect for patients, respect for self has not been discussed in detail and therefore a brief clarification of this concept is now required. Hill (1982) says that although it is said that a person with self-respect is said to have a sense of his own worth, he asks worth to whom? He believes that self-respect is when the person has personal standards or ideals and believes that he (or she) lives by them. Sachs (1982) in analyzing whether or not self-respect and respect for others are independent, concludes that persons deficient in self-respect are "sorely lacking" in respect for others.

It may be of interest to know how moral philosophers view the manner in which disrespect for self manifests itself.

Kant's views on self-respect are found in The Doctrine of Virtue: (1965) "(Man) possesses, in other words, a dignity (an absolute inner worth) by which he expects respect for himself from all other rational beings in the world." In discussing ones duties to oneself Kant lists voces one should avoid, vices which degrade one's moral being. Among these Kant lists servility, avarice and lying. Although Kant goes into self-deception at great length, which is the act of not facing the truth, he
says that no violation of a person's duty to self is worse than dishonesty. Downie and Telfer (1973-87) believe that self-respect involves being one's own master and being self-determining.

While disrespect for colleagues and the profession were well articulated by the subjects there appears to be a need to examine what respect for colleagues and the profession entails. Subjects identified the need to see oneself as professional, to act in a professional manner toward one's patients and colleagues, to continue one's education, to strive for unity among nurses and to be active in one's professional organization. One needs to ask how these behaviors are manifested in everyday practice?

Respect for colleagues is obviously manifested in the same ways as respect for any persons. But in addition, collegiality is manifested through respect for others' knowledge and the sharing of ideas. Respect for the profession entails not merely viewing nursing as a profession but acceptance of the professional values.

**Assumption 4:** Caring as an ethic in nursing is evidenced by caring for patients and families, self, colleagues and the profession. Caring for patients and families has been described under Assumption 2. Caring for self, colleagues and the profession is integral to caring profession. Caring for self is well evidenced in a short story told of the great psychiatrist Carl Jung. It is said (Kelsey, 1981) that once when a patient sought an
appointment with Dr. Jung he was told that the doctor had no more available time that week. Later the patient came to Dr. Jung and complained bitterly saying that the doctor had lied since he had seen the doctor sitting by Lake Zurich dangling his feet in the water. Dr. Jung replied, "No, I did not lie, I had an appointment with myself, one of the most important ones I ever have."

Kelsey says that caring for self involves: 1) listening to ourselves and 2) forgiving ourselves. Tubesing (1983) says that healthy persons know themselves and exhibit trust and confidence in their own ability to deal with situations when they come along. He also says that self-care involves practicing self-disclosure, reflection, developing healthy relationships and nurturing support groups.

Caring for colleagues is manifested much like caring for others in any setting in that one evidences involvement and support in professional relationships. Mayeroff (1971) says that caring is helping others to grow and to actualize themselves. With regard to manifesting caring toward the profession the ANA Code of Ethics specifies that nurses have an ethical obligation to contribute to the development of the profession's body of knowledge, to participate in the profession's efforts to implement and improve standards of care, and to participate in efforts to improve standards of employment conducive to high quality nursing care. These are the goals of the nursing profession and nurses who participate
in any or all of these efforts are demonstrating a "caring" attitude to the profession.

**Assumption 5:** Respect and caring are necessary but not sufficient properties of nursing.

The importance of respect and caring as essential properties of nursing ethics has been discussed. There are few who would disagree as to their essential nature to the art of nursing but these properties are not sufficient by themselves. Nightingale believed that nursing education should have three goals: 1) to develop self-directed individuals who would work with zeal for high principles and the benefit of their fellows; and 2) to develop nurses with understanding of the theoretical basis of health care so that they could make considered judgments and follow doctor's orders intelligently; 3) to develop nurses who would be competent in the practical procedures of nursing (Schuyler, 1975:187).

Nightingale said:

Nursing is: helping Nature to keep us in health; or to cure us in sickness - that is, putting us in the best possible condition for Nature to restore or to preserve health. Nature has laws or conditions for health and for sickness as for everything else. We have to learn them. (Schuyler, 1975:165)

In this study the subjects testified to the importance of their educational programs as being the most influential force in their views of themselves as nurses. Many also made reference to the baccalaureate as the minimum educational qualification for entry into the
profession. Therefore, one must conclude that respect and caring are insufficient by themselves for nursing.

Assumption 6: Respect for persons precedes caring in the nurse-patient relationship.

Data from this study attested to the primary nature of respect. Kant frequently claimed that every human being was an end in itself and therefore worthy of respect and he distinguishes persons from things in asserting that "respect always applies to persons, never to things".

According to Hill (1982:129) basic respect as a human being does not have to be earned. He says "if respect (for persons) is having proper regard for rights then at least some respect is due each person without his needing to earn it". This basically means that humans need not participate in order to be respected. Humans are respected by the sole virtue of being human. One needs to recall that nurses are obligated to respect the deceased. Is this a person? Regardless of whether or not one agrees respect is given to bodies.

One also needs to recall a very moving scene in the movie, "The Elephant Man". The "creature" is being chased by a mob through the London underground and when cornered cries out in desperation, "I am not an animal, I am a man." As the story unfolds one is struck by the way in which the "creature" is treated when it is discovered that he is not an imbecile. He is addressed as Mr. John
Merrick and held in high esteem. One also needs to examine the doctor's attitude. The doctor respected the creature from the beginning because of his humanity, but it was only when he began to know John that a caring relationship was evident. Mayeroff believes that respect is primary in a caring relationship. He says a person needs to be viewed as an independent person and not "used" by the care-er.

**Assumption 7:** In the absence of respect caring cannot exist.

This has been discussed before. The essence of caring is wishing a person well - wanting what is best for them. This attitude is logically impossible without first respecting them as persons. Mayeroff gives examples of a father caring for his child. Instead of dominating and wanting to possess the other one wants it to grow in its own right. Dale (1978) writes of this same idea as follows:

> Our children are persons. They are not possessions, they are not intended to become facsimiles of ourselves. They are from the very beginning human beings to be respected as persons.

**Assumption 8:** In the absence of caring nursing cannot take place.

Leininger (1981) says caring is the central and unifying domain for the body and practices in nursing. Ray (1981) says that caring is perceived as involving a
process of co-presence, giving, receiving, communication, and in essence loving in the sense that Marcel conveyed. Boyle (1981) says caring is a crucial and vital component in nursing. Bevis says concern is the closest to being synonymous with caring and likens it to Tillich's use of the term "ultimate concern". Tillich used this phrase to describe a feeling that one must act upon. Although Bevis does not use the term "duty" she says "caring" is a force, compelling action. Watson (1979) says nursing is the science of caring, which leads one to attempt to define the essence of nursing. The following definitions are provided by nursing experts.

Nightingale wrote:

Nursing is: helping Nature to keep us in health; or to cure us in sickness - that is putting us in the best possible condition for Nature to restore or to preserve health.

Henderson (1966) wrote:

Nursing is assisting the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.

Rogers (1970) wrote:

The art of nursing is the utilization of nursing's body of knowledge in service to man...Nursing exists to serve people. Its direct and overriding responsibility is to society...the safe practice of nursing depends on the nature and amount of scientific knowledge the individual brings to practice and the imaginative, intellectual judgment with which such knowledge is made explicit in service to mankind.
The ANA Social Policy Statement (1980) describes the nature of nursing as interactive and says that nursing has historically focused on nurturing, and creating a physiologic, psychologic and sociocultural environment in which the patient (and family) can gain or maintain health or heal.

These various complementary statements regarding the nature of nursing taken together provide a tapestry of what nursing is. First, it is a caring ministry, second it requires a specialized body of knowledge, third it respects the uniqueness and totality of all persons, and fourth it recognizes and respects the nurse's role in manipulating environmental forces.

It is important to point out here that these assumptions and beliefs about nursing are stated in terms of the ideal i.e., what nursing ought to be. One could make a case for the notion that the results of this study more accurately reflect what nursing is. People make nursing what it is and what it will become. If one considers the contributions of Nightingale alone one can be hopeful that some of the problems nursing is experiencing now can be solved. Care is the first step. Caring about patients and families and caring about self, colleagues and the profession.

Finally, it must be recalled that the subjects in this study valued caring as the essence of nursing for them. In fact, when they were asked to identify the value which was so important to them that they could not practice
nursing without it, more of them identified "caring" than any other value. Ozar (1987) speaks of the nursing fundamental values and principles of the profession. He says that in order to truly be a nurse one needs to have a whole hearted commitment to the principles and values of the profession. He goes on to say that one who enters with reservations about these values and principles cannot be viewed as a full member of the nursing profession. A logical inference from this statement is that a person who does not practice according to the values and principles of nursing is not practicing nursing.

**Implications for Nursing Practice, Education and Research**

The results of this study must be viewed in light of its limitations, the data having emanated from a relatively small sample of senior baccalaureate nursing students. The strengths of the study are in its method and the fundamental philosophy that a subject's phenomenological experience has validity. Guba (1980) says the qualitative investigator's goal is transferability, that is the degree of similarity among contexts. In the final analysis the results and interpretations of this study will be judged by individuals in light of its relevance to their professional lives and the meanings they derive from it.

The results and interpretations of this study are relevant to nursing practice, education and research.
Nursing Practice  The relevance of the findings and interpretations of this study to nursing practice needs to be examined in the context of the professional values. The ANA Code for Nurses and the ANA Standards of Practice are the values of nursing. Nurses are obligated to abide by these prescriptive guides of conduct. Most state boards of nursing use the ANA Code for Nurses to define professional conduct, and unprofessional conduct is cause for license suspension at the minimum and license revocation at the maximum. The results of this study reveal that unethical behavior and unprofessional behavior are the same thing and that unethical behavior is much more common than one would care to believe.

Curtin (Curtin and Flaherty, 1982) has said that in general nursing ethics has focused on the "discrete quandaries" faced by individual practitioners. She says the most obvious reason for this is that nurses desire help in resolving moral problems, but a less obvious reason is that "quandary ethics" tends to ignore the problems of professional discipline and instead focuses on how to reach a decision without due consideration of how the decision should or could be implemented. There is good reason to believe that the average nurse in practice does not associate ethics with failing to respond to a patient's light, not listening to a patient when they are speaking, addressing patients by such names as "Pops", "Gramps", "Honey", "Dearie" or just plain "Annie", etc. The point here is that nurses need to be conscious that
these are all forms of disrespect for persons and as such they are unethical. Meanwhile, the nursing literature on ethics tends to deal with issues that, while one is not saying they are unimportant, tend to obscure the meaning of everyday ethical accountability.

Caring is not easy, says Diers (1986). Nursing requires great effort, enormous amounts of energy, and above all great courage. Caring is a risky business. When one really cares and cannot stand back and watch, one must take a stand. The history of nursing has a proud heritage of risk-takers who rose to the challenge and accepted the cost, because there is always a price, but how can one do less if one is really committed.

For when conviction screams inside of you to let it live, when everything you stand for and everything you believe in wants to stay alive then dying's not so hard at all.

Blessed are you if you can believe that fully Blessed are you if you can care that well Blessed are you if you can die with love.

Dying's not so hard: it's just letting go of something so that something better can come. yes, He came to cast a fire on the earth and I am almost sure He expects us to be part of the kindling.

Blessed are you if you can suffer persecution for the cause of right!

Blessed are you if you can care that much and die that well and be that free for the Kingdom of Heaven is yours!

(Weiderkehr, M., 1979)
There appears to be no doubt that nurses need to evidence more caring in nursing practice. Miller (1979) discussed how patients become depersonalized. The first step in depersonalizing patients is to categorize them. This can be done according to disease or bed number of even "wetters" and "wanderers." Towel (1975) described how nurses treated patients as if they weren't there. This took the form of performing some task for a patient "on the side" while at the same time carrying on a conversation another staff member. Drew's study (1986) involving patients experiences with caregivers revealed that patients studied experienced exclusion or confirmation. In exclusion, patients reported being sensitive to the caregivers tone of voice and often mimicked the quality that made them feel excluded. The described caregivers quality as being cold or impersonal. Lack of eye contact was, the use of false endearments and a too casual attitude were all listed as depersonalizing experiences. Confirmation experiences were characterized by the caregiver expending energy. They described the caregiver as "wanting to be there" "liking their work" etc. patients perceived that the caregiver who moved slowly and was relaxed was more caring. Making eye contact was an important attribute as was tone of voice.

Stafford (1980) responds to the accusation that nurses give dehumanizing care with the suggestion that nurses have themselves been dehumanized. She says they have become victims of stimulus-response mentality which
excludes humane and supportive therapy. There can be no doubt that many nurses do exhibit the characteristics of victims. Feeling powerless in an oppressive physician-dominated system they often, as many oppressed groups do, assume the same characteristic that they fear and hate most in their oppressors (Friere, 1982). Yet, blaming the system can also become an excuse for immobility and apathy. There is ample evidence in this study that many nurses are not assuming the responsibility and accountability which is theirs by definition of their role. While one is well aware that there are undoubtedly circumstances and situations which tax the reserves and integrity of any human being it is also believed that many of the ethical dilemmas are simply situations in which all that is required is assertive, professional confidence and honest, caring communications.

The findings of this study have serious implications for nursing practice. It would appear that there is a need to put one's house in order. Hospital nurses need to stand firm against conditions which not only endanger the lives of patients, dehumanize them but also dehumanize nurses and undermine the whole profession. One must never lose sight of the fact that if nurses have a public image problem it may well be their own fault.

The problem of resocializing new members of the profession to renounce their professional values is serious. New members of the profession need a network of support to help them retain their commitment to the
professional values. A system of mentoring might be considered. All new graduate staff nurses would be assigned a mentor. This mentor should be someone already distinguished for high standards of practice. Not only would this provide an opportunity for the student to have a role model but it would also be viewed as a reward for the veteran nurse. This would begin a cycle of good example and these new nurses would eventually become the mentors of other new graduates. There can be no doubt the process of conforming to existing standards appears to be a vicious cycle. The cycle must be broken.

Nursing Education The results of this study support the notion that a formal ethics course in the nursing curriculum contributes to students' knowledge of ethics and what constitutes ethical conduct. Subjects also evidenced their ability to "solve" the hypothetical ethical dilemma situations. What is unknown is how a comparable sample, without benefit of an ethics course, would respond. Subjects in the pilot study were such a group but comparisons are difficult at this point due to the variances between these two groups. However, it seems important to say that the English students were equally, if not more, concerned with respect for persons which they said was mostly evidenced by disrespect and paternalism.

All the students in this study had a course in nursing ethics. An additional piece of data was that the nursing ethics text Nursing Ethics: Theories and Pragmatics by
Curtin and Flaherty uses an approach to the study of ethics which emphasizes respect and caring. This may be the strongest reason why subjects were so concerned about respect and caring.

The nursing literature has for some time now been advocating that students gain more experience with ethical dilemmas. As a result White (1983) says students are supposedly receiving formulas to solve ethical dilemmas. This type of exercise is unfortunate since one cannot prepare a solution for an ethical dilemma in advance. There appears to be a general misunderstanding about the nature of ethical dilemmas. Harding (1986) says a dilemma is (1) a valid argument between two equal alternatives, (2) there is no way to avoid choosing one of the alternatives, (3) there is no way, given the present knowledge base to know the truth of the premises a priori and (4) to be a dilemma an argument must demand resolution in the course of daily life. White (1983) says that what needs to happen is that students practice ethical decision-making. Ethical decision-making could be practiced using hypothetical ethical dilemmas. The moral principles involved could then be explored and students provide rationale for their decisions. Obviously one cannot choose a "right" answer. If a "right" answer was obvious it would not be a dilemma.

Nursing students learn respect and caring from their role models. The data evidences the importance of models, subjects describing the activities which they considered
respectful and caring. Nursing educators have an ethical obligation to respect and care for their students. It is often in this relationship that the nursing student learns what the nurse-patient relationship ought to be.

In teaching nursing ethics it may well be that the concepts of respect and caring are not in themselves conceptually interesting. Students may tune out, after all it may appear on the surface as a course in etiquette. Yet, Kant is very interesting, as are many other of the moral philosophers. Role-playing could provide some interesting experiences. What is it like to be treated as a "thing"? What is it like to be patronized and ignored? These experiences may well provide good material for classroom discussion.

While the subjects in this study were apparently well prepared in ethical decision-making they were not as well prepared for interpersonal conflict. Many evidenced the need to be accepted, to "fit in", not "rock the boat" etc, etc. How are these new graduates to maintain their standards if they do not learn to deal with the pressure to conform? One way to handle this would be to also engage in role-play. Faculty could select certain common situations and have students act out their responses. Faculty can also help students to assert themselves by being open to students complaints, perhaps by discussing with students how best to get cooperation on change. A common complaint of students is that many nursing faculty talk a great-deal about assertiveness but when the student
attempts to be assertive he or she is reprimanded for "unprofessional behavior". While one agrees that rudeness should not be mistaken for assertiveness, faculty need to help students inexperienced in interpersonal conflict, to develop skills in this area. One cannot expect nursing students to be docile and "pleasant" in nursing school and suddenly become "change agents" in the clinical setting. Many of the brightest most assertive nursing student become disillusioned in nursing education because of the double messages they receive.

Nursing Research Ellis (1979) has said that there is a need for continued systematic inquiry in nursing ethics with relevance to ethics as conceived and lived by nurses. The present study attempts to examine how emerging professionals perceive ethical nursing and through analyses and interpretation of their responses begins to clarify the major emerging concepts. Concept clarification and analysis is central to theory building. Jacobs (1986) says in concept analysis criteria are generated and used to determine the "existence" of a concept. These criteria may reflect qualitative data such as self-reports or may be inferred by an observer. In this study the criteria for concepts emerged from subjects' own words.

With regard to the finding that new graduates experience overwhelming stress there appears to be a need to examine this phenomenon further. Longitudinal studies
would be the most productive method. It seems imperative that more precise data be gathered in this area. In the same vein it would appear that studies should be conducted on the coping mechanisms of caregivers after the death of a patient. Finally, although it is impossible to replicate a qualitative study it is recommended that this study be repeated.

The importance of this study is in its effort to explicate a rarely studied phenomenon. In addition, the phenomenon was examined and described from the subjects' perspective. However further research in this area is required in order to test the generalizability of these concepts under similar conditions and also with a different population under different conditions. For example, it would be necessary to examine how these concepts are described and defined by practicing nurses in addition to student nurses and patients.

Research questions which are derived from the findings of this study are:

- How do patients and families describe respect for persons?
- In what ways does the concept of respect manifest itself?
- Is respect for patients manifested differently than respect for colleagues?
- How do patients and families describe disrespect?
- What are the defining characteristics of disrespect for persons?
- What do practicing nurses describe as the ethics of nursing?
- How do practicing nurses define "good" nursing?
- What are the defining characteristics of "good" nursing?
- How do practicing nurses define "bad" nursing?
- What are the defining characteristics of "bad" nursing?
- How is caring defined by practicing nurses?
- In what ways is caring painful?
- How do practicing nurses perceive that caring is risky?

**Summary**  This chapter concludes the dissertation. It began with a summary of the study which included a list of conclusions. A discussion of the conclusions included an attempt to explain the findings in relation to current literature in nursing and ethics. The theory emerging from the findings was presented in the form of assumptions which were then defended through the use of literature support. In the final part of chapter five the implications of the findings for nursing practice education and research were discussed.
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APPENDIX A

INFORMED CONSENT
VI. INFORMED CONSENT

I. INTRODUCTORY PARAGRAPH

"Before agreeing to participate in this study, it is important the following explanation of the proposed procedures be read and understood. It describes the purpose, procedures, benefits, risks and discomforts and precautions of the study. It also describes alternative procedures available and the right to withdraw from the study at any time. It is important to understand that no guarantee or assurance can be made as to the results. It is also understood that refusal to participate in this study will not influence standard treatment for the subject."

II. OBJECTIVES OF THE STUDY

"I agree to participate in a research study, the purpose of which is to investigate, describe and interpret how senior baccalaureate nursing students experience a commitment to professional values and to what extent they view this commitment affecting their practice."

III. PROCEDURE

"I will be required to participate in a one hour long audio taped interview during which I will be questioned on my attitudes to professional values. As a part of this interview, I will be also required to respond to a hypothetical ethical dilemma. In addition, I will provide the investigator with examples of my clinical practice such as nursing process papers and other assigned work such as clinical logs. The only benefit I will derive from this study is that a report of the study will be made available to me at a later date."

IV. "I understand that there are no risks or hazards involved in this study. I may be made uncomfortable by the questions relating to professional values but this discomfort is considered to be minimal risk."

V. "My confidentiality will be assured in the following manner: I will use a code name of my own choosing while I am being interviewed. No one but Brigid Kelly will know my contribution to the total study. I understand that the audio tapes will be destroyed at the conclusion of the study."
VI. AVAILABILITY OF INFORMATION

"Any questions that I may have concerning any aspect of this investigation will be answered by Brighid Kelly, (513) 872-5550.

VII. COMPENSATION

"The University of Cincinnati Medical Center follows a policy of making all decisions concerning compensation and medical treatment for injuries occurring during or caused by participation in biomedical or behavioral research on an individual basis. If I believe I have been injured as a result of research, I will contact Brighid Kelly at (513) 872-5550."

VIII. THE RIGHT TO WITHDRAW

"I am free to withdraw from this investigation at any time. Should I wish to withdraw, I have been assured that standard therapy for my condition will remain available to me. I have been informed of the probable consequences of my withdrawal from the study."

IX. WITNESSING AND SIGNATURES

Subject ___________________________ Date __________

Investigator ___________________________ Date __________

Witness ___________________________ Date __________

The Consent Statement should be signed by the subject (or his/her legal representative if a minor or unable to sign personally), the investigator and one witness.

Copies of the Consent Form should be placed in the subject's medical record, if one is available. The subject or the person signing for the subject must be given a copy and the investigator is required to retain a copy for his/her files.
Senior Nursing Student  
College of Nursing and Health  
University of Cincinnati  
Cincinnati, OH 45221-0038  

March 6, 1987  

Dear Student:  

I am seeking your voluntary participation as a research subject in my doctoral dissertation research.  

If you agree to participate, after having fully read the informed consent procedure, you would be required to spend one hour being informally interviewed by me. This informal interview would be audiotaped and would be scheduled at a convenient time for you sometime in Spring Quarter. During the interview, you would be asked questions regarding your views on professional ethics in practice. At the end of the interview you would be required to respond to a hypothetical ethical situation. And finally, I would require that at the end of Spring Quarter you would lend me your clinical logs from Role Transition. These would be returned to you at the end of the summer.  

If you are interested in becoming a subject in this research, but still have questions, please feel free to call me or come to see me. My telephone number is listed on the Informed Consent form. Should you decide to participate, please sign and return the consent form.  

I really appreciate your cooperation in this matter.  

Sincerely,  

Brigid Kelly  
Office #202
APPENDIX C

INTERVIEW GUIDE
(Pilot Study)
1. Greet subject and attempt to put the subject at ease by explaining the interview process. Tell the subject that you will use an interview guide which is intended to provide consistent questioning of all subjects. Explain to the subject that a clarifying question on their behalf may require that the question is repeated so that explanations of the question can be avoided.

2. Ask subjects to write a code name of their own choosing on a name card and wear it (it will be destroyed after the interview).

3. Assure the subject that most important information they can provide is their own honest beliefs and values about nursing which may or may not coincide with those of their peers, educators or significant others.

4. Turn on the tape recorder and greet the subject using the code name. Provide the data and the # of the particular interview for the record.

5. Begin the questioning:
   a) Tell me what the term professional values means to you.
   b) Provide me with a definition or a list of concepts which, in your opinion, define the values of the nursing profession.

   A follow-up question may be required:

   Are you aware of any specific guidelines which the nursing profession provides its membership with regard to values? (May also need to clarify subject's answer here by rephrasing for validation)

   c) Based upon your definition of the values (or ethics) of the nursing profession how would you describe the role these have played in your view of yourself as a beginning professional? (again, investigator may need to clarify subject's answer by rephrasing for validation)

   d) What are some of the influencing forces both positive and negative that have in your experience impacted on your present attitude (describe the attitude) to professional ethics?

   A follow-up question: (use clarifying techniques when appropriate)

   Tell me more about the most influential of these forces.

   e) In your present clinical practice what are some examples of how you view that you are applying your professional code of ethics? (follow-up questions when appropriate to clarify subject's answer)
f) In your present experience what is your view of how your professional colleagues, i.e., staff nurses, etc. accede to the professional code? (follow-up questions when appropriate)

g) In your present practice what is your view of how other professionals, i.e., physicians, act in accordance with generally accepted standards of ethical practice? (follow-up question when appropriate)

h) As you begin your professional life what are your thoughts on professional values and ethics, and do you perceive any obstacles in the way of your enactment of your professional code of ethics?

i) I am now going to read to you a situation to which I would like you to respond by telling me how you would react and what you would do were you placed in that position.

6. Read one of the ethical dilemmas by selecting one at random.

7. Conclude the interview by thanking the subject and turn off the tape recorder.

8. For pilot study only, explain to subject that they may listen to the tape and correct any false impressions in writing. Provide subject with form to evaluate the interview process.

9. Fix the tape so that no further recording can occur and so that it can't be erased.
APPENDIX D

INTERVIEW GUIDE
(Major Study)
Interview Guide
(Major Study)

1. Greet subject and attempt to put the subject at ease by explaining the interview process. Tell the subject that you will use an interview guide which is intended to provide consistent questioning of all subjects. Explain to the subject that a clarifying question on their behalf may require that the question is repeated so that explanations of the question can be avoided.

2. (a) Remind subject of the purpose of the study.
    (b) Discuss role clarification.
    (c) Discuss noncommittal affect.
    (d) Choose code name.

3. Assure the subject that the most important information they can provide is their own honest beliefs and values about nursing which may or may not coincide with those of their peers, educators or significant others.

4. Turn on the tape recorder and greet the subject using the code name. Provide that data and the # of the particular interview for the record.

5. Begin the questioning as follows:

   (a) I am interested in knowing what the expression "professional values" means to you. For instance, what does the phrase bring to your mind? You may use words, examples, anything which helps illustrate your own ideas about this concept.

   (b) Are you aware of any specific guidelines provided to nurses by the profession which give guidance in the area of conduct?

   (c) What are some examples of your professional values? In order to get at these, I would like you to think about nursing as you have experienced it, including experiences you may have had as a patient. Then tell me (1) what you think "good" nursing is, i.e., how nursing ought to be done; and (2) what "bad" nursing is and how nursing ought not to be done?

   (d) What kind of nurse are you?

   In order to answer that, I want you to reflect on not only what kind of nurse you believe yourself to be, but tell me what you think your patients would say about you -- also, your colleagues?

   (e) What are some of the influential forces which have resulted in your present view of yourself? (These forces can be both positive and negative, i.e., peers or colleagues that have been
Interview Guide (con't.)

good role models or examples of what you have learned not to do.)

Follow-up question.

What role has your formal education (i.e., schooling) had in developing your present view of yourself as a nurse?

(f) (Brief summary of values.) What are some examples from your present practice of how you view that you are applying a professional code of conduct?

(g) In considering your view of professional ethics, what is your opinion on how nurses in general accede to a code of ethics? The criteria you will use in making this judgement is the standard you have been discussing throughout this interview.

(h) Likewise, in your opinion, how do other professionals appear to you to follow this code of conduct (the one which we have defined already)? Examples of other professionals is social workers, physiotherapists, physicians, etc.

(i) You are now in a position in which you can look into the future and have a good idea of what your professional experience will be. I'd like you to tell me how you perceive that? What are your chances of practicing nursing as you believe it ought to be done?

(j) You have made the following points about nursing values and yours in particular (summary). Now, in thinking back on your responses, is there anything you would like to clarify or add to your responses?

(k) Of all the important values you have identified here today, which is the most important to you? Which value is so important you could not practice nursing without it?

I am now going to read a situation to you which I would like you to respond by telling me how you would react and what you would do were you placed in that position.

6. Read one of the ethical dilemmas by selecting odd or even.

7. Conclude the interview by thanking the subject, and turn off the tape recorder.

8. Fix the tape so that no further recording can occur and so that it can't be erased.
APPENDIX E

EVALUATION FORM
1. Did you feel that the interviewer provided you with an adequate opportunity to voice your views and attitudes about professional nursing ethics?

2. In reviewing your answers, did you think that there were areas not questioned that you considered of sufficient importance to be included?

3. If yes to above, briefly mention these areas.

4. Did the investigator give you the feeling that you had to answer in any particular way? Did she influence your answer?

5. Was there any question that you did not consider to be appropriate?

6. Were there too many questions for the time period?

7. How did the questions make you feel?

8. How important is the information received from your response to the ethical dilemma?
APPENDIX F

HYPOTHETICAL ETHICAL DILEMMAS
Ethical Situations

1 You are a hospital nurse and one of your patients has had an exploratory laparotomy and CA of the colon was diagnosed. While the patient was still asleep the doctor spoke to his family who requested that he not be told. The doctor agreed to this and puts this on the record. Several days later the patient tells you how lucky he was and that he was afraid he had cancer.

2 You are a community health nurse and you have just picked up several new cases due to the temporary absence of a colleague. Very soon you become aware of gross negligence on the part of this nurse. For example, you find a situation in which child abuse is evident yet this has not been reported and in another case you find an insulin dependent diabetic whose blood sugars have been extremely high with no intervention.
TABLE 3

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>INFLUENTIAL FORCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.A.</td>
<td>Family background which values health, life and science.</td>
</tr>
<tr>
<td>L.B.</td>
<td>Faculty the strongest influence, also very important are family, friends and previous background giving strong political opinions and values.</td>
</tr>
<tr>
<td>A.C.</td>
<td>Clinical experiences, especially primary nursing and a particular experience on the ethics of code versus no code.</td>
</tr>
<tr>
<td>R.D.</td>
<td>Nurses he has known on the job as well as those he has known in clinical (learning) settings. Feels he needs to counter the idealistic view prescribed by the instructors.</td>
</tr>
<tr>
<td>J.E.</td>
<td>Family very supportive. Faculty and patients have all been influential.</td>
</tr>
<tr>
<td>K.F.</td>
<td>Feedback from peers, co-workers and family and instructors. Being made to take the time to do things correctly.</td>
</tr>
<tr>
<td>J.H.</td>
<td>The influence of the &quot;school&quot; (of nursing), especially education in professional values and communication skills.</td>
</tr>
<tr>
<td>M.I.</td>
<td>Has learned to be tougher on self to the insensitivity of others. Biggest influence was faculty - in learning how to communicate with others in a professional manner.</td>
</tr>
<tr>
<td>V.J.</td>
<td>The faculty in helping her to become more assertive. Believes her communication has changed her.</td>
</tr>
<tr>
<td>J.K.</td>
<td>The &quot;school&quot; (of nursing) was the biggest influence - very demanding and made her work harder for what she wants - patients and families in clinical also very important influence.</td>
</tr>
<tr>
<td>SUBJECT</td>
<td>INFLUENCING FORCES</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>S.L.</td>
<td>Nurses that she has observed while working and her nursing education.</td>
</tr>
<tr>
<td>A.M.</td>
<td>Prior education in another school and a resolution to do better in nursing. Disappointments also have contributed much to own growth.</td>
</tr>
<tr>
<td>S.N.</td>
<td>Own culture and religion and the influence of the nursing school.</td>
</tr>
<tr>
<td>N.O.</td>
<td>Biggest influence was the school in changing her view of nursing.</td>
</tr>
<tr>
<td>K.P.</td>
<td>Having her own babies was a major influence. Also she was highly influenced by the school of nursing in her present view of nursing.</td>
</tr>
<tr>
<td>D.Q.</td>
<td>The perception that nursing is fighting a losing battle for a professional image. Believes nurses are not treated as professionals.</td>
</tr>
<tr>
<td>S.R.</td>
<td>Wanted to work with children and her clinical experiences were very influential.</td>
</tr>
<tr>
<td>P.S.</td>
<td>The (nursing) school was the biggest in changing her image of what nursing was.</td>
</tr>
<tr>
<td>L.T.</td>
<td>High school teachers and talking to nurses she has known over the years. Also nurses at the college as well as other places.</td>
</tr>
<tr>
<td>L.U.</td>
<td>The &quot;school&quot; (of nursing) was a major influence - some of it positive, some of it not. Also her image of nursing has undergone a great change.</td>
</tr>
<tr>
<td>F.V.</td>
<td>The instructors at the college were a major influence. Becoming aware of feminism.</td>
</tr>
<tr>
<td>F.W.</td>
<td>Family and friends who are nurses was a major influence. Also a certain professor at the college.</td>
</tr>
</tbody>
</table>

Table 3, cont'd.
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>PERCEPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.A.</td>
<td>Sees some constraints, especially health care costs to clients (example of charging patients for nurse errors) sees that one would have the power to make change, if necessary).</td>
</tr>
<tr>
<td>L.B.</td>
<td>Sees biggest constraint as her need to fit in with other nurses. Also, it depends a whole lot on the setting.</td>
</tr>
<tr>
<td>A.C.</td>
<td>Concerned that one doesn't get caught in the trap of doing things as everyone else does it. Sees time as a big constraint.</td>
</tr>
<tr>
<td>R.D.</td>
<td>Doesn't see freedom to act ethically at first (example - flushing IVs yet this is routinely done on the floors). Believes in &quot;going with the flow&quot; until one feels more confident.</td>
</tr>
<tr>
<td>J.E.</td>
<td>Doesn't really see any problem - sees own values as very basic. Sees own values as preventive - being very careful - defensive nursing.</td>
</tr>
<tr>
<td>K.F.</td>
<td>Does not think will have the freedom in nursing as sees fit. Believes that institution is a big factor and the biggest constraint is the control exercised by the medical staff.</td>
</tr>
<tr>
<td>H.G.</td>
<td>Sees physician control as a big constraint and also the institutional control.</td>
</tr>
<tr>
<td>J.H.</td>
<td>Sees bright future but believes it has a lot to do with the area of country and the institution one chooses.</td>
</tr>
<tr>
<td>M.I.</td>
<td>Believes a lot depends on self - where one works and how one allows oneself to be treated.</td>
</tr>
<tr>
<td>V.J.</td>
<td>Sees the only obstacle as self. Believes the future is what one wants it to be.</td>
</tr>
<tr>
<td>SUBJECT</td>
<td>PERCEPTION</td>
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<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>J.K.</td>
<td>Sees that nurses will increase in freedom and responsibility because of education. Sees the constraints as patient load, shortage of staff and time.</td>
</tr>
<tr>
<td>S.L.</td>
<td>Believes chances are good - assertiveness is an important factor. Sees that constraints are economic and political and pressure to conform existing standards.</td>
</tr>
<tr>
<td>A.M.</td>
<td>Doesn't think one could be a staff nurse for long. Sees the lack of power in decisions which affect the patients as the biggest problem. The constraints are the power of physicians and the power of the hospital.</td>
</tr>
<tr>
<td>S.N.</td>
<td>Believes will not stay in a place which doesn't meet standards. Doesn't worry about pressure to conform. Thinks that low staffing and time are the biggest constraints.</td>
</tr>
<tr>
<td>N.O.</td>
<td>Doesn't think it will be easy at first. Sees professionalism as a solution. Pressure to conform is always a problem.</td>
</tr>
<tr>
<td>K.P.</td>
<td>Is pessimistic about the future of nursing because of so much dissatisfaction in the ranks.</td>
</tr>
<tr>
<td>D.Q.</td>
<td>Does not see a future in nursing - is going to change to another profession.</td>
</tr>
<tr>
<td>S.R.</td>
<td>Knows won't be able to do everything would like because of time pressure and patient load.</td>
</tr>
<tr>
<td>P.S.</td>
<td>Thinks it will depend on where one works and the standards one sets for one's self - the need to hold out against pressure or to &quot;go along&quot;.</td>
</tr>
<tr>
<td>L.T.</td>
<td>Sees time as the biggest problem - also sees the pressure to conform to existing standards.</td>
</tr>
<tr>
<td>L.U.</td>
<td>Depends a great deal on where one works. Sees greater independence in areas such as labor and delivery.</td>
</tr>
<tr>
<td>SUBJECT</td>
<td>PERCEPTION</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F.V.</td>
<td>Have a good feeling about being able to practice autonomously. Still sees that the power of medicine is a major constraint and the apathy of nurses in general regarding decision-making affecting nurses.</td>
</tr>
<tr>
<td>F.W.</td>
<td>Believe the particular institution is a major factor but doesn't see a bright future for nursing because of the hardships which will be imposed because of the shortage of nurses.</td>
</tr>
</tbody>
</table>
### TABLE 5
EVALUATION OF HOW NURSES IN GENERAL ACCEDE TO CODE

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>JUDGMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.A.</td>
<td>Most of them do a good job.</td>
</tr>
<tr>
<td>L.B.</td>
<td>On the average, I would say fair...I think broadly speaking I see nurses not seeming to care about their patients or not being able to demonstrate that they do.</td>
</tr>
<tr>
<td>A.C.</td>
<td>Most of the nurses I'm working with are all close to my standard. In other places I have been they sit and gossip or sit and complain.</td>
</tr>
<tr>
<td>R.D.</td>
<td>In general, they're pretty closely approximate the code. I think its highly individualistic.</td>
</tr>
<tr>
<td>J.E.</td>
<td>Ninety percent of the nurses I've seen in the past three years would come close to my standards.</td>
</tr>
<tr>
<td>K.F.</td>
<td>It is mixed...I would say 70% to 30%. I think there are more nurses who really put forth an effort into their profession.</td>
</tr>
<tr>
<td>H.G.</td>
<td>In my experience...it has been very high.</td>
</tr>
<tr>
<td>J.H.</td>
<td>I think nurses in general are very caring people...It might depend on the point in a nurse's career and whether they still like it.</td>
</tr>
<tr>
<td>M.I.</td>
<td>I really feel nurses have worked up to my standard. The nurses I work with now are excellent. It is evident to me that they are happy with what they do.</td>
</tr>
<tr>
<td>V.J.</td>
<td>There is the good and the bad. There are many nurses that are burned out and they are just there. Then, there are others...they just shine...because they like the work.</td>
</tr>
<tr>
<td>J.K.</td>
<td>On a scale of 1-10 I would say 8 1/2 - 9 most of the nurses I've known...take the time to do the job and make sure they are doing it right.</td>
</tr>
<tr>
<td>S.L.</td>
<td>I'm not real impressed with nurses that I've met the standard I've set as my own.</td>
</tr>
</tbody>
</table>
Table 5, cont'd.

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>JUDGMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.M.</td>
<td>I would give them a 6 or so on a scale of 1-10...a lot of nurses, not all nurses, but a lot, are there for the job. They want to get their pay and go home.</td>
</tr>
<tr>
<td>S.N.</td>
<td>I would give nurses a 3 or 4 on a scale of 1-10 for caring. In general, I think it's pretty bad.</td>
</tr>
<tr>
<td>N.O.</td>
<td>On meeting the standard on a scale of 1-10, I would say 6...I think we, as a profession, have become callous to some of the things we have to do to patients.</td>
</tr>
<tr>
<td>K.P.</td>
<td>I would rate nurses a 7 on a scale of 1-10 for the standard.</td>
</tr>
<tr>
<td>V.Q.</td>
<td>Nurses in the work setting - I would give them a 5 or 6. There are a lot of good people out there...but there are a lot of that - just view it as a job.</td>
</tr>
<tr>
<td>S.R.</td>
<td>I would give nurses an 8 on the standard...Some do meet it, some don't (some) are just burned out or they have been doing this for so long it just becomes a ritual.</td>
</tr>
<tr>
<td>P.S.</td>
<td>Most of the nurses I've seen would rate a 7 on a scale of 1-10.</td>
</tr>
<tr>
<td>L.T.</td>
<td>There's alway some on the unit who would flunk the standard but in general I would give them an 8.</td>
</tr>
<tr>
<td>L.U.</td>
<td>Generally the nurses I've been with have been either an &quot;A+&quot;, very good, or they have been utterly horrible - uncaring and too busy to do anything. They are either &quot;A's&quot; or &quot;C's&quot;.</td>
</tr>
<tr>
<td>F.V.</td>
<td>I think they meet the standard for competency well, maybe an 8 or 9 but the caring I don't see. Caring I would give a 5.</td>
</tr>
<tr>
<td>F.W.</td>
<td>Most of the nurses I've come in contact with have lived up to my standard.</td>
</tr>
</tbody>
</table>
TABLE 6
IMPLEMENTATION OF ETHICS IN PRACTICE

E.A. I don't try to tell them that they have to do something. I don't think that works anyway. I think that having been there and having been with these people I had a chance to actually follow what I am saying that I believe to just allow them to make their own decisions and not be judgmental and not feel that there was a girl having her third child and all from different men and she was still to be married even once was still a person that I could come in and chat with amiably and find some basis that we could be equals on and relate to each other on and still give her whatever knowledge I had that I felt would be good for her and not put it in non-judgmental terms.

L.B. A patient asked for a snack and the staff nurse said it wasn't time yet. She was saying something that went against my values as a nurse and I couldn't think of any reasonable justification for her to withhold the snack. There did not seem to be any good reason for it. At the same time I was just there in a student role I didn't want to offend the staff nurse that I had to work with and of course I immediately had a feeling of that I wanted to protect myself. I didn't want to make her angry because then she would be mad at me and things would be very unpleasant for me...I tried to please everyone. I didn't feel satisfied afterwords. I gave my patient the snack early but I did make her wait a little while. I didn't confront the staff nurse or explain my views of the situation. I did protect myself in that I didn't get anyone angry at me.

A.C. We let people decide how they want their dressings done. Another thing I just thought of is not talking about patients outside.

R.D. One example, attending to the needs of the patient who was complaining of chest pain. I worked in Psych for three and a half years and we get kind of callous to physical complaints and we tend to dismiss them but I did go ahead and respond to this man and did an assessment and it did turn out that he did have some cardiac problems going on at the time that weren't even suspected before...Probably
Table 6, cont'd.

another example of how I didn't, the lady I mentioned was blind and I went ahead and fed her and I bathed her and I really didn't encourage her to do her own care. I feel that I should have said I would like to watch you do it and maybe make some suggestions or something of that nature.

J.E. I think by explaining the procedures before you attempt them on a patient that certainly is alerting that patient what is being done by supplying them with all the information they need to make a valid decision about a test or procedure whatever that you will not be doing. Just simply to me looking out for the best interest on a daily basis. Checking the arm bands, things like that.

K.F. I try to do that with my patients each day. It is a little more difficult when you have a heavier patient load but while I am giving morning care I always listen to them what they have to say or if I am just popping in to check on their IV I will try to take a few minutes to try to listen to what they are saying. I try to be as much a patient advocate as I can and arranging from the littlest thing as calling the dietary to get something ordered for their tray or dealing with the doctors regarding just something the patient does not want or I feel that is necessary for them. I try to implement as much of that as possible.

H.G. By sitting with them one person sticks out particularly that I just worked with this weekend is just having a terrible time. Very nice kid...We don't interact on a real consistent basis but it being that I am not really working with him so much as I had been with other kids but you can see the relationship growing and I think it's because I do take the extra time to make sure everything is OK with him or with his folks or whoever is staying with him. I think that's a big thing. The dying issue that really hasn't come up a whole lot and I haven't really pressed it because I think that that issue is hard enough to deal with as it is and I think if it would be brought up in conversation by the child or one of the parents then I think I would be more willing but in dealing with it on a conversational or interaction type thing I really haven't focused on it a whole lot.

J.H. Number one being accountable for what I do. Charting things that I do throughout the day and
the patient's status. Delivering the best possible care that I can give. Encompassing the patient holistically which means including not only physical, emotional, social and you know, many different areas. Watching what my colleagues would do. Something even like someone forgot to sign off the medications. Everyone forgets to do things but maybe it's just up here on medications but it could have been something extremely important but you don't know when they got it or if they got it. Even reminding them when they come in for the next shift. Did you give that medication? Did you sign it off?

M.I. I try to encourage them to self-care. I don't want to baby them but I am also there to encourage them to get well and see the dark side. There is a lighter side to the dark side. I try to treat them as a person not as a patient. I enjoy talking with them and interacting with them.

V.J. I try to maintain confidentiality by pulling the curtain if there is something they want to say. I close the door if they are on the bedpan.

J.K. I know something that I do because of families is like when there is one parent in particular, she will call and she has four children and this is her youngest child that is in here...He has been here a year ever since he was born and he will probably be here at least six more months. He needs surgery. She will call and we will just talk about how he is doing and I will ask how she is. We will just communicate that way. She feels bad because she cannot come in there because she has three other children under the age of six. Her husband is in prison and it is hard for her. We will just talk about that. She wants to let out those feelings. When she comes in I make a point of going over to her and sitting down with her because I feel that is important. I think safety is another ethical issue. Especially for children on ventilators...You have to take the time to do it well...Do it right.

S.L. Patients' rights are at the top of my list. I said, "well, isn't that his choice - not to come in!" How can you ever say someone deserves something because they didn't choose what you thought he ought to choose?
A.M. I did a really dumb thing. I had a graduate student who was following me and it was like the second time I had mixed this up. She saw me do it. But I told my preceptor about it...I could have lied because the person was gone but I said I forgot to remind her. I took the responsibility. It was not my responsibility to give the treatment but as far as good nursing care I should have made sure the patient got the treatment.

S.N. I guess some examples just talking - I don't have any more time that any other nurse would have just taking a little more time to think and analyze some of the patients - like their behavior - like a lot of times you have a patient that constantly puts on the call light and your first instinct, "oh, why is he on the call light again - he is driving me crazy" but still what I have learned in my Psych class and other classes in school I would sit down and think, "well, what is going on with this patient?" Maybe he is insecure or maybe he needs some kind of control or maybe he needs someone back there to talk to him, he might be afraid...I had another patient this week who was very demanding...I had to step back and think of my feelings for him...I really had to recognize the feelings I had against him so I wouldn't show them when I cared for him. I still had to care for him so I guess I sort of overcame those feelings.

N.O. Ethically, I think a nurse is there to be an advocate for a patient. In the operating room there is so many times where a nurse gets so caught up with the technical side of surgical nursing that they forget about the patient and the patient is left on the OR bed looking at all those scary lights and everyone is functioning and he is forgotten about. Another thing that had happened was another man was in for an amputation and they had done a low spinal on him and he was sedated but awake for the procedure and one of the residents came in and said, "Oh, this man is not going to make much of a sacrifice" and my preceptor popped up and said, "The patient is awake, doctor."

K.P. One would be keeping the family informed. The respect for older persons. There are a lot of patients who come back and the nurses say he won't take his medicine. You feel like you are working to no avail. When doctors order tests or procedures - do they really have to be done. When
Table 6, cont'd.

D.Q. I think that it is important to sit and talk with the patient and I enjoy doing that and I think that is real important and I like to see them before and I see them when they are pre-anesthesia and then I have had a chance where I know the patients personally so I have seen them following anesthesia and I wish I could do that for every patient - and if I don't agree with something I let them know and I state my opinion and I think that is important not in the sense where you put people on the defensive, I mean you have to use good communication techniques, but if I don't agree with something I will state my opinion or if I don't think it is right or I question something I will ask and I like to obtain information as I go for rationales and things like that and I think I am practicing ethically because of my background and my knowledge base.

S.R. Well, not to discriminate against the people for any reason, age, race, their SES. To give the best care possible to everyone. I think it's important that it's quality care, competent care. If if is something you are doing for the first time and you are not sure how to do it get somebody to help you. Make sure you do know how to do it. Have someone watch you. Abide by all the standards. With any kind of medications - follow protocols. I think a big thing with children will be informed consent. Making sure you have that consent. Making sure the parents are informed. If they are real little kids they can't comprehend what is going on. You have to make sure the family is more involved with children's care and you have to really watch that because the parent has to be informed.

P.S. Everybody should give quality care. All people should be entitled to health care. There was this one diabetic lady who was going home with her daughter. I was showing the daughter how to use the syringe and just what to do to give her quality care and not make judgment. Thought that was important. Protecting patient's confidentiality. There was an AIDS patient and everybody was talking about it. It was all over the whole community. I knew about the patient before she was even in the
hospital because I knew her through the community. I made a point not to talk to anybody about it.

L.T. As far as protecting the patient - we had lots of patients go to surgery - who when I would bring them the consent form would say to me, "the doctor didn't explain my surgery to me"; I would say, "don't sign the consent form until he comes in to see you". That happened more than once.

L.U. Holistic care. Protecting the patient - in labor and delivery. How is the patient supposed to relax when there are 10 people staring at her. One time a woman was in knee-chest position and the sheet wasn't even on her and there were 10 people in their gawking, medical students - what is going on? That is physically not a good position to be in when you just feel so vulnerable. People will talk about patients, especially those who come in with "psych histories" and they will talk about what they said, what they did, how high off the wall they were and they talked about patients in a derogatory way.

F.V. In trying to treat the patient holistically, including families, those ways. I guess in being honest and trying to give the best care you can and knowing when you are not competent to give the best care that I find out what is the best way. I have definitely seen that in nursing. I haven't done that much myself because I dealt through my preceptor. I have not dealt directly with doctors or patients. Definitely very specific times of being an advocate of protecting the patient's privacy. I did that myself.

F.W. Somebody died on the floor. And they wanted a priest to come for the last rites. She died suddenly and we were able to move the body in there and contact the priest to come. And that would be an advocacy. And, I didn't rush. We didn't rush and we didn't budget time. Because that was just as important. They could hold the other person in the recovery room for a little while longer. Admitting mistakes, when I made them. I almost hung potassium piggybacks off a controller and that is against policy procedure. But I didn't do it...But I admitted that. But I was honest to my instructor.
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.A.</td>
<td>Talk to family and reassess the situation if still think patient should be told then renegotiate with both family and physician.</td>
</tr>
<tr>
<td>A.C.</td>
<td>Clarify the patient's concerns, then talk to the doctor and the family and on that basis decide what to do.</td>
</tr>
<tr>
<td>J.E.</td>
<td>Clarify with the patient what the doctor had said, then talk to the doctor and, depending upon my assessment, renegotiate with physician and family.</td>
</tr>
<tr>
<td>H.G.</td>
<td>Clarify with the patient what was said, then approach family and the physician because the patient has the right to know.</td>
</tr>
<tr>
<td>V.J.</td>
<td>Talk to family first then maybe the doctor. Then I would probably tell the patient after I had talked with them.</td>
</tr>
<tr>
<td>J.K.</td>
<td>Explore the patient's feelings and find out what he thinks is important, then I think the family and the doctor should discuss it.</td>
</tr>
<tr>
<td>A.M.</td>
<td>Explore the patient's feelings then I might talk to the doctor and then to the family and encourage them to share it with him.</td>
</tr>
<tr>
<td>N.O.</td>
<td>First go talk to the doctor and have a meeting with the family, doctor and social worker to discuss it, if that doesn't work, take it to an ethics board.</td>
</tr>
<tr>
<td>K.P.</td>
<td>First talk to the family then talk to the patient for more information and then probably the doctor and then decide what to do.</td>
</tr>
<tr>
<td>S.R.</td>
<td>Talk to the family. I might go to the doctor and find out what he thought about telling the person.</td>
</tr>
<tr>
<td>L.U.</td>
<td>Talk to the doctor then discuss the situation with his family and encourage them to re-evaluate the situation. I would tell him if they didn't and I still thought it was right.</td>
</tr>
</tbody>
</table>
**TABLE 9**

**RESPONSE TO ETHICAL DILEMMA**

**INCOMPETENT NURSE**

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>L.B.</td>
<td>Provide the proper care to the clients first then in a collaborative way approach the nurse before considering going to the supervisor.</td>
</tr>
<tr>
<td>R.D.</td>
<td>Take care of the situation that has been neglected, then confront the nurse with my findings and go from there depending on that discussion.</td>
</tr>
<tr>
<td>K.P.</td>
<td>Take measures to insure patient safety then I would confront the nurse and see if she needs help and if nothing came of that I would then report it.</td>
</tr>
<tr>
<td>J.K.</td>
<td>First of all, inform the proper authorities of the child abuse then I would talk to the supervisor about the nurse and document my interventions.</td>
</tr>
<tr>
<td>M.I.</td>
<td>First, my main priority would be those people, then I would attempt to contact the nurse, if I could not contact her, I would talk to the supervisor.</td>
</tr>
<tr>
<td>D.Q.</td>
<td>I would go to the supervisor and find out what was going on with the nurse, then I would confront her and I would also do as much as I could to correct things.</td>
</tr>
<tr>
<td>P.S.</td>
<td>Report the child abuse and document the problem, talk to the supervisor and talk to the nurse when she returns.</td>
</tr>
<tr>
<td>L.P.</td>
<td>Take care of most critical situations first, then talk to the nurse - I might report her to the supervisor.</td>
</tr>
<tr>
<td>S.N.</td>
<td>Go to the nurse and find out what's going on and from there, depending on the situation, I would go higher up.</td>
</tr>
<tr>
<td>F.V.</td>
<td>Take care of the patients first then talk to the nurse to find out what's happening with her and try to help her.</td>
</tr>
<tr>
<td>F.W.</td>
<td>Intervene with the patients and do what needs to be done then I would bring it to the supervisor's attention and then talk to the nurse.</td>
</tr>
</tbody>
</table>
APPENDIX H

Letters from Nursing Experts
November 22, 1987

1339 Suncrest Drive
Cincinnati, Ohio 45208

Ms. Brighid Kelly
College of Nursing and Health
William Cooper Proctor Hall
University of Cincinnati
Cincinnati, Ohio 45221

Dear Brighid:

I am delighted to learn that your dissertation is completed and that you will be defending very soon. I am pleased to have had a small part in its development.

We met, together with Dr. Donna Woodside, for about three hours on the afternoon of October 5, 1987. Prior to our meeting you had given me drafts of chapters 1 through 4 to review. As I understood my function, I was to examine the data supporting the categories for "fit", and point out whether I saw other explanations or categories not listed. During our meeting Dr. Woodside and I offered suggestions concerning your categories and interpretation of data. In all, I was impressed with your evaluation of the data and believe your findings are exciting. I believe they will add significantly to the understanding of how nurses perceive and approach moral matters.

I am delighted that I will be receiving a copy of the final work. Congratulations!

Sincerely,

Carroll Quinn, RN, MSN
University of Cincinnati  
College of Nursing and Health  
Procter Hall  
3110 Vine Street  
Cincinnati, Ohio 45219

November 23, 1987

Dear Brighid Kelly:

I appreciated the opportunity to consult with you on October 5, 1987 at 2:30 to 4:30 P.M. at Procter Hall. Carolyn Quinn and I were especially interested in your dissertation since we both have teaching and other responsibilities in the area of ethics. I trust our comments were beneficial in your thinking and completion of your dissertation.

Sincerely,

Donna J. Woodside, RN, EdD.